The Law Commission

Consultation Paper No. 119

Mentally Incapacitated Adults and Decision-Making: An Overview

HMSO

The Law Commission was set up by section 1 of the Law Commissions Act 1965 for the purpose of promoting the reform of the law.

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This consultation paper, completed on 12 March 1991, is circulated for comment and criticism only. It does not represent the final views of the Law Commission.

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PART I

INTRODUCTION

1.1 Item 9 of the Law Commission's Fourth Programme[1] of Law Reform prescribes an investigation into the adequacy of legal and other procedures for decision-making on behalf of mentally incapacitated adults. This item was included as a consequence of a number of approaches made to the Commission over past years; these have raised particular problems in this area and drawn attention to deficiencies in the present law which might benefit from consideration and reform. The Scottish Law Commission is also conducting an examination of the Scottish law on the personal and financial guardianship of mentally disabled adults.[2] We understand that a discussion paper is expected soon.

The Target Population

1.2 This project is intended to encompass people who suffer from such a degree of mental disorder[3] or disability that they are incapable of taking decisions for themselves. Mental incapacity should be distinguished from the broader category of mental disorder. Many mentally disordered people remain quite capable of taking some, many or all of their own decisions. We are concerned only with those who cannot do so, although there is obviously room for debate

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1. (1989), Law Com. No.185, Cm. 800.

2. Fourth Programme of Law Reform, "Judicial Factors, Powers of Attorney and Guardianship of the Incapable", Scots Law Com. No. 126, (1990), Item 17.

3. For the definition of mental disorder in the Mental Health Act 1983, see para. 2.14 below.

about what the test of capacity should be.[4] Mental incapacity should also be distinguished from the concept of vulnerability, which is increasingly used to characterise groups of people who may need either protection from harm or help in obtaining the services to which they are entitled. Some vulnerable people are also mentally incapacitated, but many are not. Nevertheless, some of the legal mechanisms available at present can be used, not only for people who are incapacitated but also for wider categories of mentally disordered or vulnerable people, and we shall inevitably have to consider these in the course of this review.

1.3 Incapacity can arise in a wide variety of mental conditions. Whilst many people face the same sort of problems regardless of the cause of their incapacity, it is also necessary to take account of the differences between them. Subject to the response to this paper, we also propose to include people who have such severe communication problems that they are unable to make themselves understood. It may be impossible to tell whether or not such people suffer from mental incapacity, but they experience many of the same problems and similar difficulties are faced by those caring for them. We welcome views upon whether it is appropriate to include this group within the project.

1.4 It is possible to identify at least four different groups amongst whom incapacity may arise:

(a) People with mental handicap

1.5 This group comprises people suffering from various kinds and degrees of mental handicap, who will usually have

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4. This is discussed in Part II.

suffered from their disability since birth. We understand that the term "learning difficulties" is now generally preferred to "mental handicap" by people within this group and those involved with them. However, the range of disorders covered by that term is so wide that there may be a risk of confusion if we adopt it for the narrower purposes of this discussion. It can cover anyone from a mildly handicapped person, who is able to lead an ordinary life like anyone else, to a person with multiple mental and physical disabilities, who is completely dependent on others. In between there are many who are capable of acquiring new skills and abilities over time, given appropriate training opportunities, and many will be capable of making some decisions for themselves if the issues are properly explained. However, these people have often been accustomed from childhood to doing as they are told, and may be more vulnerable than most to pressure and persuasion.

(b) Elderly people with mental infirmity

1.6 Old age can lead to degenerative brain disorders such as Alzheimer's Disease and varying degrees of senile dementia or confusion or agitation which can produce similar problems.[5] Deterioration in mental capacity is often very gradual and, as there tend to be good days and bad days, it can be virtually impossible to tell with any certainty when the point of legal incapacity has been reached. Short term memory tends to be lost first, so that an elderly person may not recall what he or she had for lunch, or not remember the existence of a new grandchild, yet have a good appreciation of events which occurred many years ago. Elderly people will often have expressed views on particular matters in the

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5. For a description of the symptoms and problems caused by dementia see Health Education Council, Who Cares? Information and support for the carers of confused people, (1985), pp.1-5.

past, evidence of which can offer guidance in making future decisions on their behalf. They will often be able to grant enduring powers of attorney,[6] if the need is appreciated in time, even if they have lost the actual capacity to take some of the decisions included in it.[7]

(c) People with mental illness

1.7 It is estimated that six million people, or one in every ten of the population of the United Kingdom, suffer from mental illness in the course of a year. Of these, a minimum of 3.7 million are severely affected.[8] Mentally ill people tend to present more variable problems. They are often less amenable to persuasion and may be prone to difficult or self-damaging behaviour, so that the need to invoke compulsory procedures is more frequently perceived.[9] The degree of mental illness, including the individual's insight into his condition, will often fluctuate and there may be periods of remission. How far lack of insight should be regarded as incapacity is a difficult question.[10]

(d) Brain damaged and physically ill or handicapped people

1.8 People within this group may have suffered an injury resulting in mental incapacity or be physically ill

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6. Enduring Powers of Attorney Act 1985.

7. Re K., Re F. [1988] Ch. 310.

8. Mental Health Foundation, Mental Illness: The Fundamental Facts, (1990).

9. Of all mentally disabled adults living in private households, behaviour disabilities are more common than intellectual functioning disabilities (92% as opposed to 77%) only amongst those suffering from mental illness. O.P.C.S., Survey of Disability in Great Britain: adults living in private households, (1989), p.17.

10. See paras. 2.10, 2.11 below.

or disabled to a degree which makes any meaningful communication impossible. This might include people suffering from various kinds of aphasia, or severe head injuries resulting in a coma from which the victim may or may not make a full recovery. Decisions may need to be taken in the interim. It is nevertheless important to recognise the distinction between inability to communicate a decision, and lack of capacity to make it.

The Range of Problems and Decisions

1.9 The existing law relating to decision-making on behalf of mentally incapacitated adults is fragmented, complex and in many respects out of date. There is no coherent concept of their status, and there are many gaps where the law provides no effective mechanism for resolving problems.[11] Debate, stimulated by a series of High Court decisions on sterilisation and abortion,[12] has recently focused on the obtaining of consent to serious medical procedures,[13] but the problems extend far beyond this issue.

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11. For a discussion of the main problems see generally Age Concern, The Law and Vulnerable Elderly People, (1986); The Law Society's Mental Health Sub-Committee, Decision-making and Mental Incapacity: A Discussion Document, (1989).

12. See Re D. [1976] Fam. 185; Re B. [1988] A.C. 199; Re T. (unreported) 14 May 1987, Latey J.; Re X., The Times, 4 June 1987; T. v. T. [1988] Fam. 52; Re M. [1988] 2 F.L.R. 997; Re P. [1989] 1 F.L.R. 182; Re F. [1990] 2 A.C. 1; Re C., [1990] 2 F.L.R. 527; Re G., The Times, 31 January 1991; Re E., The Times, 22 February 1991.

13. e.g. C. Heginbotham, "Sterilising People with Mental Handicaps" in S.A.M. McLean (ed.), Legal Issues in Human Reproduction, (1989), p.141; J.E.S. Fortin, "Sterilisation, the Mentally Ill and Consent to

These are becoming increasingly visible as more and more people who are or may be to some extent mentally incapacitated are living in the community. Examples of particular difficulties brought to our attention include the following:

(i) the problem of consent to medical treatment extends from the very serious issues of sterilisation and abortion to any minor routine treatment such as administering aspirin for headache or filling cavities in teeth. Where the patient is incapable of giving a valid consent, any treatment not permitted under the doctrine of necessity is a technical assault;[14]

(ii) the courts have no power to resolve disputes between estranged parents (or indeed other relatives) of mentally incapacitated adults. Thus, for example, a divorce court cannot make orders for access once a child is over the age of 18 years. Obstruction by the parent with

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13. Continued
Treatment, (1988) 51 M.L.R. 634; A. Grubb and D. Pearl, "Sterilisation and the Courts", [1987] C.L.J. 439; A. Bainham, "Handicapped Girls and Judicial Parents", (1987) 103 L.Q.R. 334; M.D.A. Freeman, "Sterilising the Mentally Handicapped" in Current Legal Problems: Medicine, Ethics and the Law, (1988), p.55; D. Carson, "The Sexuality of People with Learning Difficulties", [1989] J.S.W.L. 355; J. Shaw, "Sterilisation of Mentally Handicapped People: Judges Rule OK?", (1990) 53 M.L.R. 91; A. Grubb and D. Pearl, "Sterilisation - Courts and Doctors as Decision-makers", [1989] C.L.J. 380; R. Lee and D. Morgan, "Sterilisation and Mental Handicap: Sapping the Strength of the State ?", (1988) 15 J. Law and Society 229; F. Scroggie, "Why do parents want their children sterilised? A Broader approach to sterilisation requests", [1990] J.C.L. 35; S. Lee, "From D. to B. to T.: sterilising mentally handicapped teenagers", [1988] J.C.L. 15; S.P. de Cruz, "Sterilization, Wardship and Human Rights", (1988) 18 Fam. Law. 6; M. Brazier, "Sterilisation: down the slippery slope?", (1990) 6 Professional Negligence 25; R. Lee and D. Morgan, "A lesser sacrifice? Sterilisation and Mentally Handicapped Women" in Birthrights, (1989), p.132.

whom an adult child is living can leave the other parent with no means of seeing that child and no remedy;

(iii) it is not clear who has ultimate responsibility for making significant life decisions on behalf of adults who are not capable of doing this for themselves; examples include whether they should continue to live at home, be admitted to residential care or live independently with intensive support;

(iv) powers of intervention when there is suspicion that a mentally incapacitated person may be suffering from neglect or physical or sexual abuse are rarely invoked and may be very difficult to exercise if, for example, there is only circumstantial evidence of violence or exploitation and the person concerned defends the perpetrator or denies the problem.[15] It is not generally clear at what stage intervention against the person's apparent wishes is justified, or who should be responsible for taking this action;[16]

(v) the law makes no appropriate provision for the future of mentally incapacitated young adults who have been under local authority care as children and placed in foster

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14. Collins v. Willcock [1984] 1 W.L.R. 1172; Re F. [1990] 2 A.C. 1.

15. A recent example which received wide media attention was the death of Beverley Lewis, a multiply handicapped and profoundly disabled 23 year old woman whilst in the care of her mother, who suffered from schizophrenia. A transcript of the Coroner's conclusions and verdict at the inquest on 1 November 1989 in which he drew attention to shortcomings in the law has been forwarded to the Law Commission.

16. S. Tomlin, Abuse of Elderly People: an unnecessary and preventable problem, (1989).

homes.[17] Neither the foster parents nor the local authority have any continuing legal responsibility for these young people as individuals once they reach the age of 18, and there is no way of safeguarding their future, short of adoption whilst they are still minors or the use of guardianship under the Mental Health Act 1983, for which they may not always qualify and which is no longer designed for such situations.

1.10 The range of matters upon which decisions may need to be taken is very wide. Depending upon the degree of capacity of the person concerned, questions can arise in any of the following areas:

(i) day-to-day living, such as deciding what to eat, what to wear, when to go to bed or get up, whether to have a bath or a haircut;

(ii) activities involving more risk, for example, going out alone, crossing roads, participating in sports, going on holiday, making new friends;

(iii) major life decisions, such as where to live, whether to enter residential care, whether to get married or have children;

(iv) minor routine medical treatment and prophylaxis, such as dentistry, cervical smear tests, vaccinations;

(v) major medical treatment which may have advantages and disadvantages, such as the removal of all of someone's

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17. C.M. Lyon, Legal and other issues arising from children with severe learning difficulties being cared for away from their parents, (1989), University of Keele.

teeth and the provision of dentures, or any treatment where the benefits are evenly balanced and a significant degree of choice is involved;

(vi) medical treatment necessitating controversial ethical decisions, such as non-therapeutic sterilisation, abortion, tissue donation, cosmetic surgery, participation in medical research or HIV testing;

(vii) legal or financial matters, such as claiming benefits, managing money, buying and selling property, making a will.

1.11 It is possible for decisions on some of the matters listed above to be taken by someone else on behalf of a mentally incapacitated person, although the law is not always clear about when and how this may be done. There are other decisions which are so personal to the individual concerned that no-one may take them on his behalf if he is unable to take them for himself. Obvious examples include voting and marrying.

Competing rights and interests

1.12 There are a number of competing interests which need to be taken into account in any review of the law in this area. On behalf of the person concerned, there is a tension between maximising his freedom and autonomy and ensuring that sufficient protection is provided against abuse and exploitation. Maximising freedom or providing equality of opportunity goes beyond mere non-interference. It can, for example, imply a need actively to encourage people to take risks. Even if this has adverse short term consequences, there may be long term benefits which cannot be acquired in any other way. Nearly everyone can learn by

experience, however slowly. If harm is taken to include under-achievement and lack of fulfillment, are mentally incapacitated people put at greater risk of harm by receiving too much care and protection, or too little?

1.13 Besides the mentally incapacitated people themselves, there are others, such as doctors, social workers and carers, who have a legitimate interest in having their position clarified. At present, there is very little guidance about the extent and limits of their authority to take action or decisions on behalf of those unable to act for themselves.[18] It may not be clear whether or not a person has capacity in relation to a particular transaction, as there is no procedure for ascertaining this in advance. Professionals and primary carers need to know the source of their authority, how far it extends and where to go for guidance if they are in doubt. As matters stand, they may be forced to act on grounds of expedience or necessity without any clear principles to guide them and may find themselves open to allegations of undue influence or misconduct.

1.14 Although many mentally incapacitated people are dependent on others, some will themselves have dependants, particularly if their incapacity arose whilst they were young or middle-aged adults, perhaps because of head injuries incurred in an accident or from conditions such as

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18. See C. Dyer, "Making Decisions for the Mentally Handicapped", [1988] Law M. 29, and also The Law Society's Mental Health Sub-Committee, op. cit. Some guidance has now been given by the Department of Health and the Welsh Office in Mental Health Act 1983 Code of Practice (1990) but this is principally in relation to cases involving compulsory admission to hospital. Other aspects are covered only in very general terms.

pre-senile dementia. The spouses and children of such people have legal rights and moral claims which may not always coincide with the strict interests or wishes of the mentally incapacitated person, particularly if the disability has led to personality changes.

1.15 The rights with which we are concerned in this paper are the rights of all people to take their own decisions if they are capable of doing so, to have someone else to take decisions for them if they are not, and to protection against abuse, exploitation and neglect of duty by others who are responsible for them. It is also argued that mentally disordered or vulnerable people have rights of a different kind, to be provided with the care and services they need to meet their own particular circumstances.[19] There are indeed many responsibilities of central and local government which are designed to do this, but the level of health, educational and social services which ought to be provided for mentally incapacitated people is outside the scope of our project. In this paper, we are concerned with the machinery which may be necessary to identify mentally incapacitated people and to give them effective help in taking decisions, which may include asserting their claims to be provided with the services they need. Many would place greater emphasis on this advocacy role than upon the assumption of authority which may also be involved.

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19. L. Gostin, "The Ideology of Entitlement: The Application of Contemporary Legal Approaches to Psychiatry", in P. Bean (ed.), Mental Illness: Changes and Trends, (1983), p.27; The "entitlement" principle has, in the United States, been developed into the "right to treatment" doctrine, which stipulates that the removal of a person's liberty for psychiatric reasons carries with it a corresponding right to the necessary treatment for that disorder. S.S. Herr, Rights and Advocacy for Retarded People, (1983), chs. 4-6.

1.16 The questions raised, therefore, are how these rights may be protected, on what basis, using what criteria of incapacity, in what circumstances, by whom, to what end and with what safeguards.

The Purpose of this Paper

1.17 The purpose of this paper is to enable us to plan the future stages and direction of our work in this large and complex area: in particular, we need to decide whether to work towards a single comprehensive solution or to divide the subject up into a series of discrete projects on individual topics. Hence, the paper aims to give an overview of the civil law relating to mental incapacity, the present procedures available for making decisions on behalf of mentally incapacitated people, their shortcomings and some of the options for reform. It is not, however, our intention to re-open discussion upon the provisions for compulsory admission to hospital and compulsory treatment under the Mental Health Act 1983. These were thoroughly reviewed before the amendments which were consolidated in the 1983 Act,[20] and our principal concern is with people living in the community or informally admitted to hospital.

1.18 We hope that the response to this paper will enable us to identify which of the possible approaches to reform may be practicable and worthy of further consideration. We recognise the complexity of the task of identifying and clarifying which problem areas are inter-related and which

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20. D.H.S.S., A Review of the Mental Health Act 1959, (1976); D.H.S.S., Review of the Mental Health Act 1959, Cmnd. 7320, (1978); Report of the Committee on Mentally Abnormal Offenders, Cmnd. 6244, (1975); Reform of Mental Health Legislation, Cmnd. 8405, (1981); Mental Health (Amendment) Act 1982.

are discrete and devising possible solutions. It is evident that these may include, not only changes to the common law or legislation, but also the strengthening of informal measures, through guidance on the existing law, procedural approaches and professional practice.

1.19 We understand the need for any new system to work and to be used in practice. Progress can only be made with the fullest possible involvement of all interested groups and organisations, whether representative of the professional service-providers or of mentally incapacitated people themselves, their families or carers. We therefore intend to undertake an extensive consultation exercise. The first stage of this is the general invitation to respond to the ideas and suggestions put forward in this paper. In parallel with this, we intend to set up a number of specialist working parties to advise us upon matters of particular interest to them and to assist us in areas where they have specialist expertise. We hope that representatives of voluntary groups, mental health charities and associations, government departments and official bodies, the judiciary, lawyers, carers, social workers, psychologists, medical practitioners of all kinds, other health care professionals and academics will all be willing to participate.

1.20 The rest of this paper is divided into six parts. Part II sets the context and explores the nature of legal and mental capacity. Part III describes the existing law and the mechanisms available at present. Part IV discusses the main problems arising as a consequence of the present state of the law, broad approaches to reform and the principles and values involved. Part V looks at the experience abroad and solutions adopted in other jurisdictions. Part VI sets out some options for reform. Part VII provides a brief summary and conclusion.

PART II

THE CONTEXT AND CONCEPT OF MENTAL INCAPACITY

Recent Trends

2.1 There have been significant changes in values over the past 25 years, accompanied by a shift in professional and public attitudes towards mentally disordered people generally. The principle of normalisation, under which as much encouragement as possible is given to the integration of mentally disordered people into the mainstream of community living, has become widely accepted.[1] Much interest and concern has been stimulated about provision for and protection of mentally incapacitated people. Efforts have been made to abandon stigmatizing terminology and practices and to encourage self determination and respect for individual rights and responsibility. At the international level, this movement resulted in the United Nations Declaration on the Rights of Mentally Retarded Persons 1971, which proclaims that they have "to the maximum degree of feasibility, the same rights as other human beings" and asserts their entitlement to benefits and services which will help them to enjoy an ordinary life in the community. In many Western European and Commonwealth countries there has been a re-examination of laws relating to guardianship and mental incapacity and new legislation[2]

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1. e.g. Caring for People - community care into the next decade and beyond, (1989), Cm.849, p.12 and ch.7.

2. e.g. In Alberta, Canada, Dependent Adults Act 1978 and Dependent Adults (Amendment) Act 1985; in Victoria, Australia, Guardianship and Administration Board Act 1986; in New Zealand, Protection of Personal and Property Rights Act 1988; in Sweden, Act of 20 December 1974; in France, Loi du 3 janvier 1968; in Austria, Bundesgesetz vom 2 Feber 1983 uber die Sachwalterschaft fur behinderte Personen, Bundesgesetzblatt 1983, 55.

has emerged in an attempt to meet contemporary conditions. There have, at the same time, been a number of developments within society and professional practice which have led to a general increase in the number and complexity of the problems faced by mentally disordered adults.[3] These developments include the following:

(a) The policy of community care

2.2 This has resulted in mentally disordered adults being cared for in the community rather than in institutions.[4] The benefits of living as normal a life as possible are generally acknowledged to be superior to a narrow, regimented institutional existence. Life in a small home in the community does, however, make mentally disordered people more visible and thus more likely targets for abuse or exploitation. This could present particular dangers if, as has been alleged, community resources prove insufficent to meet the demands upon them and the necessary degree of support and supervision is not available.[5]

(b) The "greying" population

2.3 The population of Great Britain is undergoing substantial demographic change. In 1988 there were 8.9

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3. P. McLaughlin, Guardianship of the Person, (1979), p.9.

4. The average number of beds occupied daily in mental handicap hospitals and units fell by 35%, from 64,900 to 42,500, between 1971 and 1986. The equivalent figures for mental illness hospitals and units fell by 37%, from 131,900 to 82,500. Over the same period, out-patient attendances increased by 19% at mental illness units, and at mental handicap units by 2.5 times. Central Statistical Office, Social Trends 18, (1988), p.126.

5. MIND, Waiting for Community Care, (1990); Mental Health Foundation, Mental Illness, the Fundamental Facts,(1990).

million people aged 65 or over in the United Kingdom, 2.7 million more than in 1961. There were 2.1 million people aged 80 or over, nearly 50% more than in 1961. The size of this age group is projected to rise to 2.9 million by 2025.[6] The incidence of senile dementia is thought to increase from about 5% in those over 65, to over 22% in those over 80.[7]

(c) Medical advances

2.4 Medical advances which have led to an increase in life expectancy have also resulted in the survival of greater numbers of disabled babies and accident victims who would previously have died of their injuries. Medical advances have also provided a greater range of possible medical and surgical interventions and life sustaining treatments. These can give rise to complex and difficult decisions for those caring for the elderly and mentally incapacitated.

(d) Increased pace of life

2.5 There has been a general increase in the pace and complexity of modern life, particularly in an urban environment. People who, despite their limitations, could have managed in a slower paced rural society may be unable to cope with dealings with large bureaucracies like the Inland Revenue, public utilities and housing departments.

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6. Central Statistical Office, Social Trends 21, (1991), p.25.

7. Age Concern, The Law and Vulnerable Elderly People, (1986), p.15.

(e) Increased mobility

2.6 Increased mobility has contributed to the breakdown of traditional communities in which it was common to find various branches of a family living in the same vicinity. People are having fewer children. Parents of a handicapped child are now less likely to have the support of a multitude of siblings or nearby aunts and uncles, and so the burden placed on primary carers has tended to become heavier. Also, there are fewer potential family carers because of the increasing percentage of married women in employment.[8]

(f) The distribution of wealth

2.7 There have been considerable changes in the distribution and types of wealth in society. There are now many people who receive income in the form of benefits or pensions without having any significant capital assets other than their home. This income may need to be administered but will not justify the expense of receivership or professional management, which were designed for the administration of large estates and investments, the form in which wealth was traditionally held. There has also been a great increase in private home ownership,[9] which means that many more people own houses which need maintenance and repair during their lifetime. These houses may need to be sold and the proceeds of sale administered when they can no longer be occupied. Increased home ownership also means

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8. Between 1971 and 1988 the proportion of married women who were economically inactive decreased sharply from 51% to 32%, while the proportion in employment has grown from 47% to 63%. Central Statistical Office, Social Trends 20, (1990), p.68.

9. The percentage of owner occupied dwellings increased from 43% in 1961 to 67% by 1989. Central Statistical Office, Social Trends 21 , (1991), p.136.

that more people have substantial assets with which to provide for themselves or their offspring, and increases the need for legal and financial advice.

(g) Civil rights

2.8 Over the last 20 years there has been an increasing appreciation of the rights of groups of individuals in society who have previously been subject to discrimination. This reappraisal of attitudes has applied to mentally disordered adults, who have been recognised as having been subjected to regimes which involved serious infringements of their basic civil liberties.[10] This increasing rights orientation has sought to promote two distinct types of right. First, there is the right to self determination, to freedom from unnecessary constraints and interference. Secondly, there is the right to the provision of assistance and services in such a way as to facilitate their freedom of choice and enable them to maximise their potential. The first movement is represented by the Mental Health Acts 1959 and 1983, which sought to reduce the scope and use of compulsory powers and to promote so far as possible the provision of services without legal formalities. This has, however, as we shall see in Part III, resulted in fragmentation, gaps and inconsistencies in the mechanisms available for taking decisions on behalf of those who are unable to take them for themselves. The second movement has been translated into projects such as advocacy schemes,[11] and in terms of law, into legislation such as the Disabled Adults (Services Consultation and Representation) Act 1986.[12]

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10. See C. Unsworth, The Politics of Mental Health Legislation, (1987), pp. 334-343.

11. See para. 6.47 below.

12. See para. 6.48 below.

The Concept of Capacity

(a) Introduction

2.9 It is important to distinguish between the legal concepts of capacity and incapacity and the medical or psychological concepts of mental capacity and incapacity. They may well coincide for certain people in certain contexts. Frequently, however, they do not do so and this may be a source of confusion for all concerned. The purposes of the discussion which follows are: first, to explain and illustrate the variety of legal and other approaches to the definition of incapacity based on mental state; secondly, to raise the question of whether any of the particular tests of incapacity are in need of review; and thirdly, to provide a basis for deciding whether there is a common principle which might identify the people who could be covered by the new procedures discussed in Part VI.

2.10 A legal incapacity arises whenever the law provides that a particular person is incapable of taking a particular decision, undertaking a particular juristic act, or engaging in a particular activity. Incapacity can arise from a variety of conditions; historically, these included being under the age of majority, or a married woman, or of unsound mind. Under the modern law, a great many different approaches have developed to the question of capacity based on mental state. Generally, there is a presumption that the person is capable until proved otherwise, and capacity is judged in relation to the particular decision, transaction or activity involved.[13] There is also a basic

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13. Unlike under the old inquisition procedure under the royal prerogative which seems to have resulted in total deprivation of rights, apart from the right to make a will if of testamentary capacity. H.S. Theobald, The Law relating to Lunacy, (1924), pp.19-33. Also, prior

common law test of capacity, to the effect that the person concerned must at the relevant time understand in broad terms what he is doing and the likely effects of his action. Thus, in principle, legal capacity depends upon understanding rather than wisdom: the quality of the decision is irrelevant as long as the person understands what he is deciding. However, the basic test has been adapted ad hoc to meet specific situations and the precise test now employed by the common law or statute in any particular situation may be quite different. Thus, for example, the Mental Health Act 1983 itself contains three different approaches; the first in Parts II and III governs compulsory admission to hospital and guardianship, the second in Part IV governs consent to particular forms of treatment for mental disorder, and the third in Part VII governs the management of property and affairs.[14] Statutory tests for other purposes may resemble the diagnostic categories set out in the Mental Health Act 1983, or may follow common law principles or may not greatly resemble either. For certain purposes, such as compulsory admission to hospital, a test may include people who are quite capable of taking the decision, in the sense that they understand what it is and what it will mean, but are nevertheless suffering from such a degree of mental disorder that it is thought appropriate to take the decision out of their hands, either in their own interests or for the protection of others.

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13. Continued
to the Mental Health Act 1959, the property and affairs of certain groups of compulsorily detained patients were automatically subjected to the management and administrative jurisdiction of the Judge and Masters in Lunacy, without any enquiry into their actual capabilities. They accordingly suffered an imposed legal incapacity irrespective of the reality of the situation. Lunacy Act 1890, s.116(1).

14. See further paras. 2.14, 2.15 below.

2.11 A lawyer might say that such people were legally incapacitated from deciding whether or not to remain in hospital. Others, however, might draw a distinction between those who are unable to take any decision at all and those whose particular delusional system, lack of insight or otherwise abnormal mental state leads them to take irrational or unwise decisions.

2.12 We shall therefore consider first the range of approaches in English law to the definition and legal effects of incapacity based on mental state in a variety of contexts, including the difficult issue of how this question is decided. Thereafter, we shall consider some of the literature on medical and psychological tests of capacity. Whether or not a particular individual has legal capacity, can ultimately be decided only in legal proceedings. Less formal assessments of mental capacity have nevertheless to be made by a variety of people. Assessments of capacity in relation to more serious matters are generally made by doctors, frequently because the need arises whilst a person is under their care. But it has been suggested that "since assessment of an individual's capacity is largely a matter of common sense, there is no inherent reason why a health care professional must play this role. Decision-making capacity is not a medical or psychiatric diagnostic category, it rests on a judgment of the type that an informed lay person might make...".[15] If the issue of capacity comes before a court because there is a dispute or because a legal determination of capacity is required for

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15. U.S.A. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research, Making Health Care Decisions: A Report on the Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship, Vol I, (1982), p.172.

some purpose, the Judge makes his determination not as a medical expert but as a lay person on the basis of evidence from the patient's doctors, others who know him, and possibly from personal observation.[16] In practice, "rough and ready" assessments of capacity in relation to aspects of daily life are frequently made by people concerned in day-to-day care. These may often be done on an instinctive or intuitive basis. There may well be a mismatch between the tests employed by doctors and other professionals, or by family and informal carers, and those laid down by the law in relation to the particular decision in question.

(b) Legal incapacity

2.13 We shall consider first the tests and effects of incapacity in relation to decisions which may, in certain circumstances, be taken by others on behalf of an incapacitated person. The procedure for giving others the power to do so will be considered in Part III. For completeness, however, we shall also consider the tests and effects of incapacity in relation to decisions which no-one is able to take on another person's behalf. The distinction is not always entirely clear-cut, as we shall see in relation to divorce, and at least one, making a will, has been transferred from the second to the first category in recent times.

(i) Compulsory admission and guardianship under the Mental Health Act 1983

2.14 Parts I to IV of the Mental Health Act 1983 distinguish the overall category of "mental disorder", which together with other considerations is sufficient to justify

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16. Ibid.

short-term compulsory measures, from the four more specific diagnostic categories, which are generally required for longer term hospitalisation or guardianship. "Mental disorder" is defined[17] as " mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind". The four more specific categories are "mental illness", which is not defined but is clearly intended to be a distinct and more serious type of mental disorder;[18] "severe mental impairment" which is defined as "a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned"; "mental impairment", defined as "a state of arrested or incomplete development of mind (not amounting to severe mental impairment) which includes significant impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned" and "psychopathic disorder", defined as "a persistent disorder or disability of mind (whether or not including significant impairment of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned". Thus, both for the civil procedures for compulsory admission to hospital or reception into guardianship and for hospital or guardianship orders which may be made by the criminal courts, the principal test is of diagnostic category, together with a need for hospital treatment in the interests of the patient's own health or safety or for the protection of other persons. The procedures generally require the recommendation or reports

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17. Mental Health Act 1983, s.1(1).

18. W. v. L. [1974] Q.B. 711.

of two registered medical practitioners, one of whom must be an approved specialist in mental disorder.[19] They would not regard the matter as depending upon the patient's capacity, but rather upon his mental state and need for treatment. For the purpose of certain treatments for mental disorder, however, the Act does adopt an approach based on the patient's capacity to consent.[20]

(ii) Management of property and affairs under the Mental Health Act 1983

2.15 Part VII of the Mental Health Act 1983 deals with the management of the property and affairs of mentally disordered people. The powers of the judge or Master of the Court of Protection are exercisable when the court is satisfied, after considering medical evidence, that "a person is incapable, by reason of mental disorder, of managing and administering his property and affairs".[21] The definition of mental disorder is the very broad one contained in section 1(1) of the Act,[22] but the emphasis is on assessment of functional capacity rather than diagnostic categories. Specialist medical evidence is not statutorily required, although it may be necessary if the issue is disputed. Where conflicting medical evidence is presented, it is for the court to decide which to prefer. Once the court has assumed jurisdiction, the person concerned becomes legally incapable of engaging in any transaction relating to his property and affairs even though he may, in fact, be

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19. Mental Health Act 1983, ss.2(3), 3(3).

20. See para. 2.25 below.

21. Mental Health Act 1983, s.94(2).

22. See para. 2.14 above.

capable of doing so. The only exception is a will, which he remains able to make if he has testamentary capacity.[23]

(iii) Contracts

2.16 A contract entered into by a person who is not subject to the jurisdiction of the Court of Protection, but is mentally incapable of making it, is binding on him if the other party reasonably believed him to be of full capacity at the time when the contract was made.[24] The test of capacity is whether the person was capable of understanding the general nature of what he was doing.[25] The degree of understanding required is relative to the particular transaction and varies according to the circumstances from a low degree where the subject matter and value are trivial to a high degree where the effect of the contract or gift is to dispose of the party's only asset of value.[26] The criterion of understanding is similar to the test of, for example, testamentary capacity,[27] but the effects of incapacity are very different. In contract, a mentally incapacitated person will be bound unless he can prove that the other party knew of his incapacity. The desirability of protecting those who cannot protect themselves gives way in the face of the need to avoid prejudicing the other party because of incapacity which he had no reason to suspect. It is arguable, therefore, that the contractual position is in truth a rule of unconscionability rather than a rule of capacity. The practical effect, however, is the same.

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23. See para. 2.17 below

24. Imperial Loan Company v. Stone [1892] 1 Q.B. 599; approved in Hart v. O'Connor [1985] A.C. 1000.

25. Chitty on Contracts, 26th ed., (1989), para. 617.

26. In re Beaney [1978] 1 W.L.R. 770.

27. See para. 2.17 below.

The main exceptions to this general rule are contracts for the supply of "necessaries",[28] for which a mentally incapacitated party has a statutory obligation to pay a reasonable price where they have been delivered to him, regardless of whether the supplier knew of his incapacity. Another exception is a contract made by a patient whilst his property and affairs are subject to the jurisdiction of the Court of Protection. The patient cannot make any contract which is inconsistent with the court's powers and any such contracts are voidable whether or not he actually had capacity at the time, and whether or not the other party knew of the involvement of the Court of Protection.[29]

(iv) Wills

2.17 The basic principles governing testamentary capacity were laid down in a series of nineteenth century cases which decided that a testator must be of sound mind, memory and understanding.[30] "[H]e ought to be capable of making his will with an understanding of the nature of the business in which he is engaged, a recollection of the property he means to dispose of, of the persons who are the objects of his bounty and the manner in which it is to be distributed between them...".[31] Thus, a testator is not only required to pass the ordinary test of understanding the nature of his act and its broad effects, but must also pass

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28. Sale of Goods Act 1979, s.3(2). "Necessaries" are goods suitable to his station in life and to his actual requirements at the time.

29. Re Walker [1905] 1 Ch. 160; Re Marshall [1920] 1 Ch. 284.

30. See, for example, Boughton v. Knight (1873) 3 P.& D. 64, 65; Smith v. Tebbitt (1867) 1 P.& D. 398; Harwood v. Baker (1840) 3 Moore P.C. 282.

31. Harrison v. Rowan 5 Washington at p. 585, cited in Banks v. Goodfellow (1870) 39 L.R. 5 Q.B. 549, 567.

a memory test of recalling the extent of his property and a further test of awareness of the moral obligations owed to relatives and others. A valid will may be made by a person, including a patient of the Court of Protection, who is frequently subject to delusions, or whose condition fluctuates, provided that it is executed during a lucid interval, or his particular delusions have not influenced the disposition of his property.[32] However, since 1969, the Court of Protection has had power to make a statutory will on behalf of a person who is not only incapable of managing his property and affairs but also incapable of making a will for himself.[33]

(v) Medical treatment

2.18 It is a basic common law principle that every person's body is inviolate, and that any intentional touching of it, however slight, may amount to a trespass or battery if it takes place without consent.[34] Thus, any medical procedure involving touch, and particularly surgery, performed without consent is a tort. This rule has been modified by a number of exceptions, the principal one of which, in relation to medical treatment, is the doctrine of necessity.[35] Necessity provides a justification for medical treatment which would otherwise be a battery. Thus, a doctor is entitled, and probably has a duty, to carry out

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32. See generally Williams, Mortimer and Sunnucks, Executors Administrators and Probate, 16th ed., (1982), ch.12.

33. Mental Health Act 1983, s.96(1)(e), (4)(b).

34. Collins v. Willcock [1984] 1 W.L.R. 1172.

35. The other main exceptions are self defence, parental authority, prevention of a crime, effecting a lawful arrest, ejecting a trespasser and the inevitable physical contacts and vicissitudes of everyday life. Collins v. Willcock, supra; Wilson v. Pringle [1987] Q.B. 237.

such emergency treatment as is necessary to preserve the life and health of an unconscious patient, notwithstanding that he is unable to give or withhold his consent.

2.19 For consent to medical treatment to be effective as a defence to an action for battery, it is enough that the patient's consent is "real", in the sense that he understands in broad terms what is involved.[36] A doctor may also be liable in negligence if he does not fulfil the duty of care owed to his patient. This duty includes, in addition to the obligation to exercise professional care and skill in diagnosis and treatment, an obligation to advise the patient, inform him about the treatment, and warn him of any significant risks.[37] But this does not mean that the patient has to be fully "informed". There has been some difference of opinion about the amount of information which should properly be disclosed.[38] This can depend to some extent upon the condition and state of mind of the patient and upon the nature of the medical procedure involved. But it has been held[39] that the decision is primarily one for the doctor to take,[40] governed by his common law duty to use

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36. Chatterton v. Gerson [1981] Q.B. 432; P. Fennell, "Inscribing Paternalism in the Law: Consent to Treatment and Mental Disorder" (1990) 17 J. of Law and Society 29, 31.

37. Sidaway v. Board of Governors of the Bethlem Royal Hospital [1985] A.C. 871.

38. See, for example, the dissenting judgment of Lord Scarman in Sidaway, supra.; various articles in S.R. Hirsch and J. Harris (eds.), Consent and the Incompetent Patient: Ethics, Law and Medicine, (1988); Law Reform Commission of Victoria, Informed Consent: Symposia 1986, (1987).

39. In Sidaway, supra.

40. Ibid.at p. 900, per Lord Bridge at p.900D "I do not see that this approach involves the necessity `to hand over to the medical profession the entire question of the

professional care and skill; and that this duty will usually be discharged if he acts in accordance with a practice accepted as proper by a responsible body of medical opinion skilled and experienced in the specialty concerned.[41]

2.20 Hence, the test of capacity to consent to most forms of medical treatment is based on the usual common law criterion of understanding in broad terms the nature and likely effects of what is to take place. The leading case on the treatment of mentally incapacitated adults, however, is Re F. (Mental Patient: Sterilisation).[42] This was not concerned with the test of capacity, or with who should decide whether or not a patient was incapable, but with the question of what treatment could (and should) be given in the absence of valid consent. The House of Lords held that, there being no procedure for giving someone else the right to decide on behalf of a mentally incapacitated person,[43] there was also no jurisdiction in the court to

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40. Continued
scope of the duty of disclosure, including the question whether there has been a breach of that duty.' Of course, if there is a conflict of evidence as to whether a responsible body of medical opinion approves of non-disclosure in a particular case, the judge will have to resolve that conflict. But even in a case where... no expert witness condemns the non-disclosure as being in conflict with accepted and responsible medical practice... the judge might in certain circumstances come to the conclusion that disclosure of a particular risk was so obviously necessary to an informed choice on the part of the patient that no reasonably prudent medical man would fail to make it."

41. Bolam v. Friern Hospital Management Committee [1957] 1 W.L.R. 582.

42. [1990] 2 A.C. 1.

43. See paras. 6.26-6.29 below.

approve or disapprove the giving of treatment. But the court could grant a declaration that it would be lawful to proceed in the absence of consent, if the treatment was justified on the principle of necessity. This principle was further held to mean that the lawfulness of operating upon or otherwise treating a mentally incapacitated person depended upon whether such treatment was in the patient's best interests.[44] In the case of non-therapeutic treatments, such as sterilisation, it was highly desirable as a matter of good practice, but not mandatory, for an application to be made to the court for this to be determined in advance.[45] The standard to be applied in determining the patient's best interests was held to be the same as that laid down in the case of Bolam v. Friern Hospital Management Committee [46] (and approved by the House of Lords in Sidaway v. Board of Governors of the Bethlem Royal Hospital[47]) as the test in the law of medical negligence; that is, the doctor must act in accordance with a practice accepted as proper by a responsible and competent body of relevant professional opinion.[48] Applying this test, the declaration that the sterilisation would not be

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44. Lord Goff said at [1990] 2 A.C.1, 75H that, to fall within the principle of necessity "not only (1) must there be a necessity to act when it is not practicable to communicate with the assisted person, but also (2) the action taken must be such as a reasonable person would in all the circumstances take, acting in the best interests of the assisted person". Lord Brandon said at p. 56D that the application of the principle of necessity did not depend upon the approval of the court, but "on the question whether the operation or other treatment is in the best interests of the patient concerned".

45. Lord Griffiths dissenting on this point.

46. [1957] 1 W.L.R. 582.

47. [1985] A.C. 871.

48. See para. 2.22 below.

unlawful was upheld.[49] The procedure has been followed in a number of subsequent cases,[50] but it has recently been held that there is no requirement to seek a declaration before performing an abortion.[51] For most forms of treatment, therefore, the application of the doctrine of necessity by those responsible for the patient will suffice.

2.21 It may be helpful to separate the issue of sterilisation, and perhaps other particularly controversial measures, from the general run of medical, dental and surgical treatment. Even if it is accepted that the patient's "best interests" should govern the matter, there is obviously room for a great deal of debate about how the best interests of a mentally incapacitated woman should be judged. How great is the risk that she will have sexual intercourse or become pregnant? If she is incapable of agreeing to sterilisation, is she capable of agreeing to sexual intercourse? Should she be protected against that? If in fact she understands and enjoys sexual intercourse, can she also understand the nature and effect of other forms of contraception? How great are the risks either to her or

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49. Cf. the approach taken to this issue in other jurisdictions. The leading Canadian case is Re Eve [1986] 2 S.C.R. 388 where the court refused to authorise a sterilisation operation on a mentally retarded woman because "it can never be safely determined that such a procedure is for [her] benefit". The Family Court of Victoria, Australia held in Re "Jane" (1988) 85 A.L.R. 409 that such an operation should be performed on a 17 year old mentally retarded girl as being in her best interests and for her welfare, but held that the consent of the court is always necessary, as a matter of routine, in order to perform non-therapeutic medical procedures on a child or mentally incapacitated adult. See further para. 5.9 below.

50. e.g. Re C. [1990] 2 F.L.R. 527.

51. Re G., The Times, 31 January 1991.

her baby were she to become pregnant? There may, of course, be good reasons to suppose that sterilisation will be best for her, but there are also risks that it will be best for those around her. A special procedure, with prescribed criteria, may well be appropriate here.

2.22 Quite apart from the sterilisation issue, the decision in Re F. has been criticised upon a number of grounds, particularly in relation to the definition of necessity and the choice of the best interests standard as a measure of justification.[52] What factors are relevant in evaluating the patient's best interests? Lord Brandon said that "The operation or other treatment will be in the best interests of such patients if, but only if, it is carried out in order either to save their lives, or to ensure improvement or prevent deterioration in their physical or mental health".[53] This suggests that the test is limited to medical interests, and it is not entirely clear whether or not other considerations may be taken into account.[54] In the case of non-therapeutic or controversial medical procedures, there are often (if not always) likely to be relevant ethical and social considerations. Also, this test does not encourage a sufficent distinction between the different issues which arise depending upon whether the operation is to correct a condition which would be

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52. A. Grubb and D. Pearl, "Sterilisation - Courts and Doctors as Decision Makers", [1989] C.L.J. 380; D. Morgan, "Recent Cases: F. v. West Berkshire Health Authority", [1990] J.S.W.L. 204; P. Fennell, (1990), op. cit., pp. 43-45; J. Shaw, "Sterilisation of Mentally Handicapped People: Judges Rule OK?", (1990) 53 M.L.R. 91; M.A. Jones, "Justifying medical treatment without consent", (1989) 5 Professional Negligence 178.

53. [1990] 2 A.C. 1, 55E.

54. See D. Morgan, op. cit., p.206.

detrimental even if the patient were not incompetent, and a condition that is thought to be detrimental only because he is incompetent.

2.23 There is also a view that best interests is not the most suitable test, particularly in the case of a patient who has previously had capacity and may have expressed opinions on the subject, or left other evidence of what his wishes might be.[55] In such a case it might be preferable to adopt the "substituted judgment" standard, by which the court attempts to place itself in the shoes of that particular person, and to decide the matter in the way he would have decided it, taking full account of any idiosyncratic views he may have held.[56]

2.24 Furthermore, it is one thing to say that "best interests" are the test, and quite another to say that "best interests" are to be judged by what a responsible body of medical opinion would consider acceptable, even if another would not. A test developed to deal with matters of clinical judgment is not necessarily the most appropriate one to use in circumstances where the balancing of other interests may be required.[57] It is certainly not the approach adopted by the courts when assessing the best interests of a child whose care and upbringing fall to be

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55. See paras. 4.22, 4.23 below.

56. For an example of the operation of the substituted judgment standard in a different context, see Re D.(J.) [1982] Ch. 237.

57. See Grubb and Pearl, op. cit., and also D. Morgan, op. cit.

decided in legal proceedings.[58] It would be absurd to apply a different test when permitting the sterilisation of an 18-year-old from that applicable to the sterilisation of a 17-year-old under the wardship procedure.[59] As it has been forcefully expressed, "is it imaginable that any other group of people could have their best interests restated as simply the right not to have others make negligent decisions in relation to them?".[60]

2.25 The Mental Health Act 1983 makes special provision for treatment for mental disorder in certain circumstances. Most patients detained under the Act[61] can be given treatment for the mental disorder from which they are suffering without their consent.[62] However, certain treatments can only be given either with the patient's "informed consent" or with a second, independent medical opinion.[63] Further, there are certain particularly controversial treatments which cannot be given to any patient, whether or not he is detained under the Act, without both his "informed consent", independently

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58. Guardianship of Minors Act 1971, s.1; Children Act 1989, s.1; J. v. C. [1970] A.C. 668.

59. Re B. [1988] A.C. 199.

60. D. Carson, "The Sexuality of People with Learning Difficulties", [1989] J.S.W.L. 355, 372.

61. Mental Health Act 1983, s.56(1).

62. Ibid., s.63.

63. Ibid., s.58; the treatments are the administration of medicine for the patient's mental disorder for longer than three months and electro-convulsive therapy; Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983, S.I. 1983/893, reg. 16(2)(a).

certified as such, and an independent medical opinion.[64] The test of capacity to consent to these treatments is that the "patient is capable of understanding the nature, purpose and likely effects of the treatment in question".[65] The stringency of this test depends upon the degree of understanding required by those operating the Act's procedures, which can in practice amount to more than the "broad terms" required by the common law.[66] The Code of Practice under the 1983 Act[67] states that in order to have capacity an individual must be able to understand what medical treatment is, that someone has said he needs it and why the treatment is being proposed; understand in broad terms the nature of the proposed treatment; understand its principal benefits and risks; understand what will be the consequence of not receiving the proposed treatment and possess the capacity to make a choice.

(vi) Marriage and divorce

2.26 Unlike the decisions discussed so far, marriage (and to some extent divorce) belong to the class of acts

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64. Ibid., s.57; the treatments are any surgical operation for destroying brain tissue or for destroying the functioning of brain tissue and the surgical implantation of hormones for the purpose of reducing male sexual drive; Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983, S.I. 1983/893, reg. 16(1)(a).

65. Mental Health Act 1983, ss. 57(2)(a), 58(3)(a),(b).

66. R. v. Mental Health Act Commission ex parte W, The Times, 27 May 1988; P. Fennell, "Sexual Suppressants and the Mental Health Act", [1988] Crim. L.R. 660, 670-674.

67. Department of Health and Welsh Office, Mental Health Act 1983: Code of Practice (1990), para. 15.14 "the assessment of a patient's capacity to make a decision about his own medical treatment is a matter for clinical judgment guided by current professional practice and subject to legal requirements".

which are personal to the individual concerned and cannot be carried out by anyone else on his behalf. To be capable of marriage, the bride or groom must, at the time of the ceremony, understand the nature of the contract being entered into.[68] As marriage is a relatively simple concept, the degree of understanding required is fairly low compared to some other transactions.[69] Whilst a marriage contracted before 1 August 1971 would be void in the absence of a valid consent, marriages after this date are voidable,[70] because of lack of consent due to "unsoundness of mind". Lack of consent due to unsoundness of mind is still established by the common law test, although the grounds for annulment are now prescribed by statute. Alternatively, even if there has been a valid consent, since 1937, a marriage has been voidable if the bride or groom was suffering from mental disorder within the meaning of the Mental Health Act, "of such a kind or to such an extent as to be unfitted for marriage".[71] In relation to divorce, it has been held that the validity of a mentally disordered respondent's consent to a decree of divorce under Divorce Reform Act 1969, s.2(1)(d) depended on whether the respondent had the capacity to understand the nature of the consent and to appreciate the effect and result of expressing it.[72] This, like marriage, is a personal

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68. Hunter v. Edney (1885) 10 P.D. 93.

69. e.g. making a complicated will. See In the Estate of Park, Park v. Park [1954] P. 112.

70. Matrimonial Causes Act 1973, s.12, re-enacting Nullity of Marriage Act 1971, s.2.

71. Ibid., s.12(d). See Bennett v. Bennett [1969] 1 W.L.R. 430.

72. Mason v. Mason [1972] Fam. 302.

decision; but if the patient is incapable of managing his affairs, his guardian ad litem may produce a similar result by deciding not to defend a petition based on another "fact".

(vii) Sexual intercourse

2.27 This too must be a matter for personal choice by the individual, so that if he or she is incapable of making the decision, no-one may make it for them. The common law test of capacity to consent to sexual intercourse in general follows the usual form, that the person concerned must be capable of understanding what is proposed and its implications and exercising choice.[73] Statutory limitations have, however, been imposed upon the capacity of certain groups of people to give a valid consent to sexual intercourse with the aim of protecting people with mental disorder from exploitation and abuse. Thus, it is an offence for a man who is an employee or manager of a mental nursing home or hospital to have unlawful sexual intercourse with a mentally disordered patient receiving treatment there, or attending as an out-patient if the offence is committed on the premises. Similar provisions exist where the woman is under his guardianship, or otherwise in his custody or care under various statutory provisions.[74] The Sexual Offences Act 1956 imposes wider restrictions upon the ability of anyone suffering from a "state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning"[75] to

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73. Thus, it is rape to have intercourse with a girl or woman who cannot understand the implications of what is taking place. R. v. Howard [1966] 1 W.L.R. 13.

74. Mental Health Act 1959, s.128.

75. Sexual Offences Act 1956, s.45 as amended by Mental Health (Amendment) Act 1982, s.65 and Schedule 3, para. 29.

consent to sexual intercourse. This is the same wording as in the definition of "severe mental impairment" under section 1 of the Mental Health Act 1983[76] but without the additional need to show abnormally aggressive or seriously irresponsible conduct. It is an offence for a man to have sexual intercourse with, or procure for sexual intercourse, any woman who comes within this category,[77] unless he has no reason to suspect her of doing so.[78] Severely handicapped men are protected against homosexual acts in similar circumstances,[79] and neither men nor women within this category can give a valid consent to an indecent assault.[80] One problem with these provisions is that they may cover people who are in fact capable of giving a real consent to intercourse or other sexual activity, but have a statutory incapacity imposed upon them by the criminal law. The men involved in these cases may often be handicapped themselves, and it seems unfair that they should automatically be at risk of prosecution if there has been no exploitation involved. In some circumstances, these provisions of the criminal law could be seen as imposing an unwarranted fetter upon the freedom of mentally incapacitated people.[81] They can also pose problems for staff who may fear, even if they do not risk, prosecution for aiding and abetting.

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76. See para. 2.14 above.

77. Sexual Offences Act 1956, ss.7(1) and 9(1) as amended by the Mental Health Act 1959, s.127(1).

78. Ibid., s.7(2) and 9(2) as amended by the Mental Health Act 1959, s.127(1).

79. Sexual Offences Act 1967, s.1(3),(4).

80. Sexual Offences Act 1956, ss.14(4), 15(3).

81. M.J. Gunn, "Sexual Rights of the Mentally Handicapped", in E. Alves (ed.), Issues in Criminological and Legal Psychology No. 10: Mental Handicap and the Law, (1987), p.31.

(viii) Jury service

2.28 A large number of mentally disordered people are ineligible for jury service, irrespective of their actual capacity to perform the duties of a juror competently and responsibly, whilst others who may well be incapable are not automatically excluded.[82] There are three categories of ineligibility, the main one covering anyone who suffers or has suffered from mental illness, psychopathic disorder, mental handicap or severe mental handicap and because of that is either resident in a hospital or similar institution, or regularly attends for treatment by a medical practitioner.[83] The other two categories cover anyone under guardianship and anyone whose property and affairs are administered by the Court of Protection. The list does not include severely handicapped people who are living in the community and not receiving regular medical treatment.

(ix) Voting in elections

2.29 At common law, people suffering from mental incapacity cannot vote in elections, other than during a lucid interval.[84] It seems to be a question of fact for the presiding officer to decide whether at the moment of voting, a voter is sufficiently competent to discriminate

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82. Juries Act 1974, s.1 and Schedule 1 as amended by Mental Health Act 1983, Schedule 4, para. 37.

83. These terms are construed in accordance with the Mental Health Act 1983, s. 1(2). See para. 2.14 above. The definitions of mental handicap and severe mental handicap are the same as the definitions of mental impairment and severe mental impairment in s.1(2), but without the reference to abnormally aggressive or seriously irresponsible conduct.

84. Bedford County Case, Burgess' Case (1785) 2 Lud. E.C. 381; Bridgewater Case, Tucker's Case (1803) 1 Peck 101.

between candidates and answer the statutory questions in a satisfactory manner. Thus, the usual test applies: whether the individual can in broad terms understand what he is doing and the effects of his action. However, it can happen that a form of statutory incapacity is imposed upon people who may be competent by the common law criteria, if they cannot meet the residence and other requirements necessary to register on the electoral role of their home ward or constituency. A compulsory patient cannot be treated as resident at any place where he is detained, and an informal patient cannot be treated as resident at any mental hospital in which he is living although he can be registered elsewhere.[85]

(ix) Giving evidence in court

2.30 Mentally disordered adults are in a similar position to children when giving evidence in court, but there is no statutory provision allowing them to give evidence without taking an oath or affirmation.[86] Thus, a mentally disordered adult may only give evidence if he understands the duty to tell the truth and also the nature and consequences of an oath.[87] A lack of such understanding does not, however, necessarily mean that the person concerned is unable to give an account of what has happened to him. Evidential problems may make it particularly difficult to obtain convictions for offences against mentally disordered people. In addition to the capacity problem, and the ordinary corroboration rules, it may sometimes be necessary to warn the jury of the danger of

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85. Representation of the People Act 1983, s.7(1)-(3).

86. Such as Children and Young Persons Act 1933, s.38; Children Act 1989, s.96(1),(2).

87. R. v. Dunning [1965] Crim.L.R. 372.

convicting on the unsupported evidence of certain mental patients.[88] Judges and juries may also be inclined to regard the evidence of mentally disordered people, be they victims or defendants, with a degree of suspicion through unfamiliarity with the nature and effects of particular kinds of disability. Psychiatric evidence as to capacity could sometimes be helpful here, but there is some debate about the degree to which such evidence may be adduced. It is not generally admissible where the defendant is "normal" in the sense of not suffering from a recognised mental illness or mental handicap,[89] even if he has an unusual personality.[90] It may be admissible, if relevant, when the defendant's condition is outside the range of "normality" and thus beyond the experience of the ordinary person.[91] The difficulty arises in drawing the line between normality and abnormality in areas where conditions fluctuate and cannot easily be measured. It is also arguable that the distinction is irrational as psychiatry has to explain normal mental processes before abnormal ones can be understood;[92] psychiatric evidence should therefore have the same validity in either context.

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88. It has, for example, been held that in cases where the prosecution witnesses are patients in secure hospitals, juries should be warned of the danger of convicting on their unsupported evidence as they may be unstable or bear a grudge, R. v. Spencer [1987] A.C. 128, but cf. R. v. Bagshaw and Others [1984] 1 W.L.R. 477; some aspects of the ruling in Spencer are currently under review as part of our project on the corroboration of evidence in criminal trials; see (1990) Working Paper No. 115.

89. R. v. Turner [1975] 1 All E.R. 70; R. v. Roberts [1990] Crim.L.R. 122.

90. R. v. Weightman, The Times, 8 November, 1990.

91. R. v. Masih [1986] Crim.L.R. 395.

92. A.A.S. Zuckerman, The Principles of Criminal Evidence, (1989), p.67.

2.31 There are special rules relating to the admissibility of confessions made by mentally disordered people. A confession may be inadmissible if obtained by oppression of the person who made it.[93] When considering whether there has been oppression, the court is entitled to take into account the type of person involved and may bear in mind mental incapacity or limited intelligence.[94] The Police and Criminal Evidence Act 1984 introduced additional protection for mentally handicapped defendants by requiring a judge to warn the jury of the "special need for caution" before convicting a defendant when the case against him depends wholly or substantially on a confession, the court is satisfied that he is mentally handicapped and his confession was not made in the presence of an independent person.[95] However, this applies only to people who are "in a state of arrested or incomplete development of mind which includes significant impairment of intelligence and social functioning",[96] and does not extend to people who may be vulnerable owing to forms of mental disorder falling outside this definition.

(xi) A general principle?

2.32 The common law test of capacity, combined with the doctrine of necessity laid down in Re F. for cases of incapacity, could be seen as a possible solution to the general problems involved in making decisions for those unable to do so for themselves. Indeed, there are dicta in Re F. which suggest that the "best interests" principle does apply to every type of care which a mentally disordered

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93. Police and Criminal Evidence Act 1984, s.76.

94. R. v. Westlake [1979] Crim. L.R. 652.

95. Police and Criminal Evidence Act 1984, ss. 77(1),(2).

96. Ibid., s.77(3).

person may need.[97] In some respects, these common law principles have much to commend them. They are extremely flexible and can, with a little ingenuity, be adapted to most situations. They are consistent with modern ideas about adopting the least restrictive approach in that they can be used as needed without stigmatising formalities or depriving the individual concerned of any other civil or legal rights. To this extent they are compatible with the idea of incapacity as a fluctuating concept, although some might consider they set the threshold of capacity too low. But as a general solution to the problem, they are subject to many criticisms, some of which have already been discussed,[98] and leave a number of questions unanswered.

2.33 One fundamental criticism of Re F. is that (in strong contrast to the law's approach to patients' property) the doctrine of necessity apparently leaves to the individual doctor the momentous task of deciding whether or not a person is incapacitated. There may be a great temptation to decide that the patient is incapacitated, even though he may actually be capable of understanding the "broad terms" explanation required by the common law. Unless the patient actively objects, an issue may never be raised. There are obvious risks in adopting this approach, even in the context of medical treatment where decisions are generally taken by highly responsible professionals without a personal and financial interest in the outcome. In other contexts, the risks are even more obvious and severe.

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97. e.g. Lord Goff at [1990] 2 A.C. 1, 77-78.

98. See paras. 2.21-2.24 above.

2.34 Furthermore, if an issue is raised, either as to the patient's capacity or as to his "best interests", the common law does not provide a simple and inexpensive mechanism for resolving cases of doubt. In many cases, it is possible only to obtain a definitive decision after the event, when it may be too late. The procedure for obtaining a declaration, adopted in Re F., is expensive and time consuming. Applying it to most everyday situations would be ridiculous. Also, little guidance is given upon exactly what can and cannot be done without using any formal mechanisms, when it is and when it is not desirable to seek a declaration, and who should take this decision. Only Lord Griffiths, dissenting, said that the consent of the High Court should be necessary for sterilisation to be lawful.[99] The rest of the House agreed only that recourse to a court was highly desirable as a matter of good practice. But there is no sanction if those responsible for the patient decide to sterilise her without going to court.[100] There may be good reasons to suppose that sterilisation is not in her best interests, which will never be considered if nobody is prepared to object.[101]

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99. [1990] 2 A.C. 1, 70.

100. A. Grubb and D. Pearl, "Sterilisation and the Courts", [1987] C.L.J. 439, 455-6 suggest, but reject, three possible sanctions, namely a prosecution under the ancient crime of maim, apparent consent being rendered void on public policy grounds and disciplinary proceedings against the doctors before the General Medical Council for serious professional misconduct under the Medical Act 1983.

101. In Re D. [1976] Fam. 185 only the persistence of the educational psychologist brought the matter before the court. The girl's mother and gynaecologist were agreed that the sterilisation should be performed. See S. Trombley, The Right to Reproduce: a history of coercive sterilisation, (1989), pp. 207-210.

2.35 Thus, the common law fails in crucial areas to address the general problem of identifying incapacity. There are two important questions, what should the test of incapacity be, and who should decide upon it? In areas where the courts have developed tests of capacity, such as capacity to marry, or testamentary capacity, these are not readily accessible to or understood by lay people. This may not matter in situations where legal advice is likely to be sought in any event or where, as in Re F., the issue of incapacity is clearly not in dispute (although it often could be in such cases). But, considering the varying degrees and fluctuating nature of incapacity, identification may be of vital importance in circumstances where there is doubt about an individual's ability to decide for himself. Otherwise, a capable person's objection may all too readily be overridden.

(c) Medical and psychological tests of capacity

2.36 Although capacity is a legal concept, attempts to establish it invariably rely on a medical or psychiatric assessment, and, in relation at least to questions of consent to treatment, doctors are primarily responsible for raising the issue. It may therefore be enlightening to look at tests of capacity from the medical and psychological as well as the legal point of view. The analysis of medical and psychological tests appears to have received comparatively little attention in this country. Anecdotal evidence suggests that present methods used for the assessment of a patient's responses often tend to be subjective and empirical, rather than consciously attempting to apply a consistent standard. Whilst decisions about capacity at either end of the spectrum may be straightforward, borderline cases can present intractable problems, and it is consequently hard to be confident that a universal "pass mark" is being applied.

2.37 Research in the United States of America and Australia has suggested that doctors' decisions are influenced by two major extraneous factors, their "attitude to client group" and a "treatment bias".[102] The former hypothesis maintains that doctors' attitudes to mentally disordered or disabled people are unduly influenced by their own images of them, and that this affects the judgment made of their abilities in a particular field, the consequent assessment of their competence in that area and the threshold set for the assessment of capacity.[103] The treatment bias theory maintains that medical practitioners are inherently predisposed to favour a decision to treat a patient. They are therefore more likely to find patients who are agreeable to treatment to be competent, than those who are uncooperative.[104] This leads to tests of competence being adjusted according to the patient's attitude and the risk/benefit ratio of the proposed treatment, "to achieve the desired medical or social end".[105] Thus, low tests of competence will be selected

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102. A. Rassaby, "Informed Consent to Medical Care by Persons of Diminished Capacity", in Law Reform Commission of Victoria, Informed Consent: Symposia 1986, (1987), p. 77; Roth, Meisel and Lidz, "Tests of Competency to Consent to Treatment", (1977) Am. J. Psychiatry 134:3, 279, 283.

103. The example given by Rassaby op. cit., at p. 80, is that of a doctor who views a particular adult as childlike. It is suggested that his view of that person's ability to care for children will be influenced accordingly, and that this might affect his estimation of the patient's competence. If a sterilisation operation is being considered, a low threshold of capacity may be required. For an example of the "attitude to client group" problem in practice see R. v. Mental Health Act Commission ex parte W., The Times, 27 May 1988; Fennell, (1988), op. cit.

104. Rassaby, op. cit., at p. 80. See also President's Commission, (1982), op. cit., pp. 61-62.

105. Roth, Meisel and Lidz, op. cit.

for patients who consent to treatment with a favourable risk/benefit ratio, or refuse treatment with an unfavourable one, and high tests of competence for those who make the opposite choices.

2.38 A seminal analysis of tests of competence in the United States,[106] identified five separate tests: evidencing a choice, "reasonable" outcome of choice, choice based on "rational" reasons, ability to understand and actual understanding. Subsequent commentators have identified a number of shortcomings and pitfalls in these individual standards,[107] and have attempted to refine this analysis into a more workable system. One review of current concepts of capacity and clinical approaches to its assessment integrates the various tests in an attempt to overcome some of their limitations,[108] and suggests that in order to be found competent in relation to a particular decision a patient must reach a certain standard in each of four categories:

(i) communicating choices and maintaining a stable choice long enough for it to be implemented. The ability to express choices is tested by asking a patient who has been informed about a proposed procedure to respond to what he has heard. The stability of the choice is tested by repeating the question several minutes later;

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106. Ibid.

107. A.M. Tepper and A. Elwork, "Competence to Consent to Treatment as a Psycholegal Construct", (1984) 8 Law and Human Behaviour 205-223.

108. P.S. Applebaum and T. Grisso, "Assessing Patient's Capacities to Consent to Treatment", (1988) 319 23 N.Eng.J.Med. 1635-8.

(ii) understanding relevant information which requires a memory for words, phrases, ideas and sequences, intelligence and a reasonable attention span. The patient's ability to remember may be tested by asking him to repeat information, and his ability to understand, by asking him to paraphrase it;

(iii) appreciating the situation and grasping what it signifies for him. Attributes include acknowledging illness when it is shown to be present, evaluating its effect and the treatment prospects and recognising the general probabilities of risks and benefits;

(iv) manipulating information rationally by reaching conclusions which are logically consistent with the starting premises. The patient's chain of reasoning can be examined by asking him to indicate the major factors in his decision, and the importance assigned to them, then assessing whether the outcome generally reflects these factors.

2.39 These criteria could be combined to create a very high threshold of capacity. There is, for example, no guidance upon deciding how much information is relevant under (ii). A doctor could insist upon full comprehension of detailed technical matters. The "chain of reasoning" criterion (iv) is open to very subjective interpretation. A doctor might easily decide his patient was incompetent because he did not personally accept that certain values and preferences the patient had, or certain risks he was prepared to run, could rationally be taken into account or be allowed to determine a particular outcome. As a consequence the patient could be denied the freedom to act irrationally (or at least against reason), even if he wanted to do this, knew what he was doing and why.

2.40 An alternative approach[109] draws on psychological analyses of the decision-making process and proposes a general definition of competence to consent to treatment which can be quantitatively adjusted depending on the context in which and the purpose for which it is being used. The definition consists of two main dimensions, the presence of decision-making abilities, and the absence of decision-making disabilities. The former proposes that "a patient's competence to [consent to] treatment depends on his or her ability to (i) understand the relevant information necessary to reach a decision, (ii) deliberate about the information needing to be considered in reaching a decision and (iii) decide to accept or reject a proposed plan of treatment".[110] The decision-making disabilities which may prevent an individual from exhibiting one or more of these abilities include an initial failure to develop the abilities or loss of them through trauma resulting in permanent organic damage, interference caused by other psychological processes such as hallucinations or delusions or feelings of euphoria or depression sufficient to prevent any meaningful concentration or discussion.

2.41 In its report, the President's Commission identified the following elements of capacity,[111] (i) possession of a set of values and goals to provide a stable framework for comparing options, (ii) the ability to communicate and understand information, including linguistic and conceptual skills, plus sufficient life experience to appreciate the meaning of potential alternatives, and (iii) the ability to reason and deliberate about one's choices in

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109. Tepper and Elwork, op. cit.

110. Ibid. p. 214.

111. President's Commission, (1982), op. cit., pp. 57-62.

a way which enables comparison of the probable impact of alternative outcomes on personal goals and lifestyles. As is acknowledged, measuring these abilities is far from easy, but it is suggested that any standard which looks solely at the content or reasonableness of a decision is inadequate. Disagreement with a decision should be the beginning of an evaluation of the patient's capacity, not the end of it.

2.42 In 1977, one of the first attempts to analyse the components of capacity likened the search for a single test of competence to a search for the Holy Grail which would never end "unless it is recognised that there is no magical definition... getting the words right is only part of the problem. In practice judgments of competency go beyond semantics or straightforward applications of legal rules; such judgments reflect social considerations and societal biases as much as they reflect matters of law and medicine."[112] An unsuccessful quest may nevertheless be valuable if it shows only that a pragmatic approach is the most workable way. There is no one "right" method of assessing capacity, but a broad consensus can be reached upon the test which should be applied and the main considerations which should be taken into account.

(d) Should the law be changed?

2.43 Three main approaches to capacity are identified in the literature. The "outcome" approach, the "status" or "category" approach, and the "function" or "understanding" approach.[113] Under the "outcome" approach, capacity is

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112. Roth, Meisel and Lidz, op. cit.

113. President's Commission, op. cit., pp.169-171; M.B. Kapp, Preventing Malpractice in Long Term Care: Strategies for Risk Management, (1987), pp. 116-117.

determined by the content of the individual's decision. A decision which is inconsistent with the views and values of the assessor, or rejects conventional wisdom is by definition incompetently made. The "status" or "category" approach judges an individual's capacity according to his physical or mental status, such as age, place of residence or diagnosis, without any further inquiry into how membership of that category affects his competence as an individual. This may sometimes be a convenient method when a fairly arbitrary rule of thumb is required: for example, "no-one under the age of eighteen is competent to vote in elections". But it has obvious dangers and is clearly inadequate in circumstances where a more sophisticated technique is needed properly to reflect the complexities involved. For example, an assertion such as "all patients on long-stay geriatric wards are incompetent to execute a will" is clearly a gross and misleading oversimplification. The main difficulty with the status and outcome approaches is that, whilst they may be useful as indicators of possible incapacity, they take insufficent account of personal values and perspectives and tend to undermine respect for individual rights. As the President's Commission has said "the fact that a patient belongs to a category of people who are often unable to make general decisions for their own well-being or that an individual makes a highly idiosyncratic decision should alert health care professionals to the greater possibility of decisional

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113. Continued
But cf. I. Kennedy and A. Grubb, Medical Law: Text and Materials, (1989), at p. 181, who argue that the "outcome" approach is not properly a concept going to the notion of capacity, but rather a means of demonstrating its presence in a particular case and thus one of a number of possible criteria which may need to be satisfied.

incapacity. But it does not conclusively resolve the matter."[114]

2.44 Although the outcome and status approaches are probably applied frequently in everyday practice,[115] the third approach, the "function" or "understanding" approach has received by far the greatest informed support.[116] It also happens to be the approach most frequently adopted in theory by English law.[117] This approach focuses upon the personal ability of the individual concerned to make a particular decision and the subjective processes followed by him in arriving at it. In short, does he understand the general nature and likely consequences of what he is deciding and can he communicate his decision? This approach emphasises the fluctuating nature of capacity. Absolute incapacity will be rare except in the case of the comatose patient. For most mentally disordered or disabled people, competence is decision-specific; that is, they may be capable enough to make some decisions, but not others. Additionally, it has been suggested that[118] there is a responsibility upon the assessor to maximise the patient's abilities by conducting the assessment in a manner which

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114. Op. cit., p.171-172.

115. Kapp, op. cit., p.117.

116. President's Commission, op. cit., p.171; Kapp, op. cit., p.117; Skegg, Law Ethics and Medicine, (1984), pp.56-7; Kennedy and Grubb, op. cit., pp.181-190; Age Concern Institute of Gerontology and Centre of Medical Law and Ethics, The Living Will: Consent to Treatment at the End of Life, (1988), pp.25-26; Roth, Meisel and Lidz, op. cit., p.279.; The Law Society's Mental Health Sub-Committee, Decision-making and Mental Incapacity: A Discussion Document, (1989), p.3.

117. See paras. 2.14-2.31 above.

118. Applebaum and Grisso, op. cit.

facilitates optimum performance. For example, the assessor should be experienced in evaluating mental capacity and familiar with relevant legal standards and the medical implications of the person's condition. The person should be supplied with sufficient information upon which to base his decision, presented in readily understandable forms. If it appears that he has not understood it, the assessor should attempt to explain it before concluding that incomprehension is due to incapacity. The subjective element should be minimised by the assessor recognising the problem and adopting a structured approach. The assessment should be repeated on more than one occasion before a finding of incapacity is made to allow for the possibility that the patient's capacity fluctuates. Finally, efforts should be made to ensure that the assessment takes place in an atmosphere which puts the patient at ease, for example, in familiar surroundings, with a family member or regular nurse present, and perhaps with an assessor from his own cultural or ethnic background. Nevertheless, there may be some "functions" for which this basic understanding is not enough and it is necessary to question the quality of a person's insight and thought processes.

2.45 The following questions arise for consideration:

(i) Is the present approach of the law in defining capacity in terms of understanding correct, and should this "function" approach be continued?

(ii) For what purposes might this approach not be sufficient?

(iii) Are any of the specific tests of capacity unsatisfactory and in need of review?

(iv) In particular, is there scope for achieving greater uniformity between them, so as to reduce the risks of misunderstanding and provide greater clarity for professionals and others who have to operate them in practice, often without resort to the courts?

(v) Is further guidance needed for professionals and carers on the practical application of tests of capacity and how should this be supplied?

PART III

THE PRESENT LEGAL MECHANISMS

3.1 There are a number of existing legal procedures available to provide substitute decision-makers for some categories of mentally disordered or disabled people. These operate in different ways and fall into two broad groups, those dealing with property and finance and those dealing with personal care and treatment. Between them they no longer cover the whole range of decision-making on behalf of mentally incapacitated people. A brief historical account may be helpful in understanding how this situation has come about.

The Historical Perspective

3.2 The right to wardship of the property and person of someone of unsound mind developed from a feudal entitlement into a royal prerogative, the existence of which was recognised in the Statute De Praerogativa Regis.[1] This drew a distinction between the treatment of "idiots", who had been of unsound mind since birth, and "lunatics", whose "wit and memory had failed". The King was entitled to keep profits over and above those required to maintain the former, but was required to account for those of the latter. The prerogative was exercisable only after an inquisition and a finding of idiocy or lunacy by a jury, but findings of idiocy seem to have been rare because of the drastic consequences, and the principal purpose of the procedure was

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1. Thought to date from 1275-1306, (17 Edward II, c.9 and 10), H.S. Theobald, The Law relating to Lunacy, (1924), pp.1-63.

to protect the property and person of the patient.[2] Throughout the eighteenth and nineteenth centuries various statutes[3] were passed regulating the conduct of inquisitions and the exercise of the prerogative, the majority of which were consolidated in the Lunacy Act 1890.[4] The powers of the Crown were delegated to the Lord Chancellor by a Royal Warrant under the Sign Manual, which was re-issued at the beginning of every reign. Under these powers, the Lord Chancellor could appoint and control a committee of the estate or of the person of the patient, or of both.

3.3 However, powers exercisable under the royal prerogative applied only to "lunatics so found by inquisition", generally those who were wealthy and had relatives interested in the preservation of their land and property. The prerogative was not invoked for other mentally disordered people, often paupers or vagrants whose numbers far exceeded the former, and whose treatment and rights were unregulated by statute until the introduction of the Vagrancy Acts. "Wandering lunatics" were first mentioned in the Vagrancy Act 1714. This was followed by the Vagrancy Act 1744, which authorised two Justices of the Peace to direct the detention in a secure place of persons "ferociously mad or... so far disordered in their senses that they may be dangerous to be permitted to go abroad".[5] The main purpose of these Acts was repressive, to clear

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2. Ibid.; C. Unsworth, The Politics of Mental Health Legislation, (1987), p. 47.

3. See Theobald, op. cit., p. 23; and e.g. Lunatic Commissions Act 1833, Lunacy Regulation Act 1853, Lunatics Law Amendment Act 1862.

4. See generally K. Jones, A History of The Mental Health Services, (1972) and Unsworth, op. cit.

5. Vagrancy Act 1744, s.20.

"Rogues, Vagabonds, Beggars and other idle and dishonest persons" off the streets.[6] But the only specialist places available for mentally disordered people were in Bethlem Hospital or in private madhouses run for profit. By the late eighteenth century, the conditions in private madhouses had become a public scandal[7] and a stream of reforming legislation was enacted in an attempt to remedy the abuses and to establish publicly funded asylums for people unable to pay for private care.[8] The increasing use of institutional care, however, led eventually to calls for greater safeguards against mistaken or malicious admissions; these culminated in the Lunacy Act 1890, which consolidated all the legislation in this area. Further powers were subsequently created in the Mental Deficiency Acts 1913 and 1927, which sought to provide a separate code for the care of "mental defectives", whereby they could be placed under guardianship, and funds were supplied to provide for their care and accommodation in public institutions.

3.4 By the mid-twentieth century, great advances had taken place in psychiatry, in attitudes to mental disorder and in the development of health and welfare services. The approach of the 1890 Act, with its emphasis on compulsory institutionalisation and elaborate legal safeguards, was increasingly seen as inappropriate and out of date. The first steps towards reform were taken in the Mental Treatment Act 1930. This provided for the reorganisation of the central administration concerned with mental

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6. Unsworth, op. cit., p.53.

7. See Jones, op. cit., ch. 2.

8. e.g. The Act for Regulating Private Madhouses 1774; The County Asylums Acts 1808 and 1828; The Madhouse Act 1828; Lunatic Asylums Act 1842; Lunatics Act 1845.

illness.[9] It made provision for out-patient clinics and after-care,[10] and created special procedures for voluntary treatment and the temporary compulsory admission of patients likely to recover rapidly.[11] The Act applied, however, only to the mentally ill, and not to people suffering from other forms of mental disorder. In 1953, a Royal Commission was set up under the chairmanship of Lord Percy, and in 1957 it published a detailed and wide-ranging report.[12] Most of the report's recommendations were incorporated in the Mental Health Act 1959, which repealed all previous legislation and created a new code intended to make comprehensive provision for the care of all mentally disordered people and their property. The Royal Warrant under the Sign Manual authorising the Lord Chancellor to exercise the royal prerogative was revoked when the Act came into operation in 1960. Separate procedures were provided for the care of a patient's property and affairs through the Court of Protection,[13] and for his personal care and treatment under compulsory powers of admission to hospital[14] and guardianship.[15] In combination, these could be used to take decisions over every aspect of a patient's life, although in practice this was very rarely done. The basic principle underlying the Act was the freedom of all mentally disordered people to be cared for informally in so far as possible, with "compulsory procedures being an adjunct to

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9. Mental Treatment Act 1930, ss. 11-15.

10. Ibid., ss. 6-10.

11. Ibid., ss. 1-5.

12. Report of the Royal Commission on the Law relating to Mental Illness and Mental Deficiency, Cmnd. 169, (1957).

13. Mental Health Act 1959, ss.100-121.

14. Ibid., ss.25-29.

15. Ibid., ss.33-34.

the voluntary system, rather than the reverse".[16] Mental disorder and the criteria for the compulsory procedures were redefined in modern terms and new procedures were created for the compulsory detention of patients which did not involve a judicial confirmation that detention was justified, as had previously been the case. It was felt that this was unnecessary, as the main concern was now the wellbeing and treatment of each patient, rather than the protection of society, and the detention process could consequently safely be left in the hands of the professionals.[17]

3.5 The 1959 Act was widely recognised as a liberal and broadly successful innovation, particularly in its emphasis upon informal treatment and care, and the idea that it was unnecessary always to assume legal control over all aspects of an individual's life. However, despite its undoubted benefits, problems were experienced over the operation of parts of the Act, which led to allegations of misuse or malpractice,[18] particularly in the area of compulsory admission and treatment. The growing civil rights movement in the 1960's and 1970's highlighted criticism of and disenchantment with what was seen as medical paternalism and over-reliance on psychiatric judgment.[19] Amendments made

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16. R. Bluglass, "The Origins of the Mental Health Act 1983: Doctors in the House", Bulletin of the Royal College of Psychiatrists, (1984), p.127. Informal and voluntary are, however, not the same. See para. 3.19 below.

17. For an analysis of the factors leading to this see Unsworth, op. cit., pp. 231-235.

18. Jones, op. cit., pp. 327-330.

19. L. Gostin, A Human Condition: The Mental Health Act from 1959 to 1975: Observations, analysis and proposals for reform, (1975), (Vol.I); D.H.S.S., Review of the Mental Health Act 1959, (1976); D.H.S.S., A Review of the Mental Health Act 1959, Cmnd. 7320, (1978).

in 1982,[20] and consolidated in the Mental Health Act 1983,[21] represented something of a return to the civil liberties approach. The diagnostic categories and criteria for compulsory admission to hospital or guardianship were redefined with the effect of substantially reducing their applicability to mentally handicapped people.[22] Procedural safeguards were introduced dealing expressly with the issue of consent to treatment for mental disorder in hospital.[23] The powers of guardians were reduced,[24] but without providing any alternative solution to the issue of consent to other forms of medical treatment.[25] There was no longer any machinery for assuming responsibility for every aspect of a completely incapacitated person's life.

Property and Finance

(a) The Court of Protection

3.6 The Court of Protection was placed upon a fully statutory footing by the Mental Health Act 1959, taking over from the old prerogative jurisdiction so far as it related

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20. Mental Health (Amendment) Act 1982.

21. See Bluglass, op. cit., at p.130 for an account of the passing of the Bill through parliament.

22. e.g. Mental Health Act 1983, s.1(2) replaced the division of the mentally handicapped into the subnormal and severely subnormal with new concepts of mental impairment and severe mental impairment which required a patient to satisfy a behaviour criterion before being brought within the terms of the Act. Thus the mental impairment must be "associated with abnormally aggressive or seriously irresponsible conduct".

23. Mental Health Act 1983, ss.56-64; see para. 2.25 above.

24. Ibid., ss.7-10.

25. See paras. 3.24-3.26 below.

to a person's property and affairs. Its operation is now governed by Part VII of the Mental Health Act 1983[26] and by the Court of Protection Rules 1984.[27] The Court exists to safeguard the interests of anyone who is, after the consideration of medical evidence, found "incapable by reason of mental disorder of managing and administering his property and affairs".[28] Anyone meeting these criteria is known as a "patient". Administratively, the Court of Protection is part of the Lord Chancellor's Department, but it is also an office of the Supreme Court and a court of law, with its own judiciary. There is a full-time Master and nominated judges from the Chancery Division of the High Court sit in the Court of Protection from time to time. Strictly speaking, the Court's responsibility is limited to legal and financial matters,[29] although this can be a difficult dividing line to draw in practice. The Court's duties are normally carried out by appointing a receiver for a patient. Its administrative functions are now carried out by the Public Trust Office which has a Protection Division which oversees the work of external receivers, and a Management Division which acts as receiver of last resort.[30]

3.7 The receiver is the patient's statutory agent. His powers are limited and specified in the order appointing him and a further direction or authority of the Court is

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26. ss.100-121.

27. S.I. 1984/2035.

28. Mental Health Act 1983, s.94(2) as amended by the Public Trustee and Administration of Funds Act 1986, s.2.

29. Re W.(E.E.M.) [1971] Ch. 123; Re F. [1990] 2 A.C. 1.

30. Public Trustee and Administration of Funds Act 1986, ss. 2, 3.

required for matters outside the scope of the order. Receivers are expected to visit the patient at least once a year and to account, usually annually, to the Court for their dealings with the patient's property. The Mental Health Act 1983[31] gives the Court power to authorise virtually any legal or financial transaction on behalf of the patient, including investments, the sale and purchase of property, the making of gifts and settlements and the conduct of legal proceedings. If the patient is of testamentary capacity he may make a will for himself in the usual way;[32] if he is not, the Court has power to authorise the execution of a statutory will on his behalf.[33] There is no express statutory guidance upon the test the Court should apply in making decisions on the patient's behalf beyond its power to do whatever is "necessary or expedient" for the maintenance or benefit of the patient, his family or other dependants.[34] It has, however, been held that "benefit" is not confined to financial or material benefit but includes anything which promotes the genuine interests of the patient and his family.[35] In relation to the execution of statutory wills, it has been held that the Court should try to make for the particular patient the will he would have made for himself if competent to do so, taking account of any idiosyncratic views he may have held.[36] In effect, a "substituted judgment" standard is to be

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31. ss.95, 96.

32. Heywood and Massey, Court of Protection Practice, 11th ed., (1985), pp. 181-5.

33. Mental Health Act 1983, ss.96(e), 97.

34. Ibid., s.95(1).

35. Re E. (Mental Health Patient) [1985] 1 W.L.R. 245.

36. Re D.(J.) [1982] Ch. 237.

applied.[37] Where the appointment of a receiver is unnecessary, but a formal authority or directions are required for some purpose, the Court has power to provide these comparatively quickly and inexpensively by means of a Short Procedure Order.[38] Invoking the jurisdiction of the Court of Protection in respect of the property and affairs of a patient has the effect of suspending his ability to act for himself in all areas within its jurisdiction, even if he actually has the capacity to do so in some respects, or from time to time.

3.8 Under the Court of Protection Rules 1984, the Court is required to charge fees for the commencement of proceedings for the appointment of a receiver,[39] and for various transactions authorised by it.[40] An annual administration fee is also payable in every receivership, calculated on an ascending scale proportionate to the patient's annual income.[41] Short Procedure Orders can be obtained on payment only of a commencement fee,[42] but they are in practice limited to cases where the patient's property does not exceed £5000 in value or where capital is safely invested, income is all used on the patient's maintenance and there is no continuing need for the Court to be involved. Short Procedure Orders will not, for example, normally be made when there are rents or dividends to be received, or property to be managed or disposed of.

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37. See paras. 4.22, 4.23 above.

38. Court of Protection Rules 1984, r.41(1)(a).

39. Ibid., r.78.

40. Ibid., rr.80, 81.

41. Ibid., r.79.

42. Currently £50.

Although the Court has power to remit or postpone the payment of fees,[43] it has acquired a reputation for expense which, depending upon the circumstances of the patient, may or may not be justified, but which contributes to the general reluctance to invoke its jurisdiction, and to the sometimes strenuous efforts which are made to avoid it.[44]

3.9 The Court of Protection has in the past been criticised for being remote, inaccessible, slow and bureaucratic.[45] It is arguably unduly paternalistic in its procedures, whereby, for example, the Court's jurisdiction can be invoked on a single medical opinion. The criteria used to define "mental disorder" and "incapacity" are said to be imprecise, and arrangements for representing the patient's own point of view to be generally inadequate.[46] Much has been done to improve the Court's procedures and accessibility since 1983 and some of these criticisms are less true now than formerly,[47] but the reputation exists and, because comparatively few lawyers or other

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43. Ibid., r. 83(1) "where in its opinion hardship might otherwise be caused to the patient or his dependants or the circumstances are otherwise exceptional".

44. e.g. Health Education Council, Who Cares? Information and Support for the carers of confused people, (1985), p.36, "Carers who have used the Court of Protection have found it very costly and say they would try and avoid using it if at all possible for this reason".

45. See generally L. Gostin, The Court of Protection: a legal and policy analysis of the guardianship of the estate, (1983).

46. Age Concern, The Law and Vulnerable Elderly People, (1986), pp.81-83.

47. In the foreword to Heywood and Massey, op. cit., the present Master, Mrs. A.B. Macfarlane says "Since I was appointed Master at the end of 1982 I have been trying to act, to some extent, as a public relations officer for the Court of Protection". Examples include a talk to a British Association for Service to the Elderly

professionals deal with the Court on a regular basis, there is still a good deal of misunderstanding about its operation. It is perhaps inevitable that the management of 22,000 cases spread throughout the country by a staff of about 300 civil servants based in London will have some shortcomings.

(b) Enduring powers of attorney

3.10 The Enduring Powers of Attorney Act 1985 came into operation on 10 March 1986. The Act provides a procedure whereby a power of attorney, if made in the prescribed form, can continue after the donor becomes mentally incapable.[48] An enduring power of attorney can confer on the donee general or specific authority to act on the donor's behalf.[49] If the attorney has reason to believe the donor is or is becoming mentally incapable, he must apply to the Court of Protection to register the power and notify the donor and his closest relatives of the application.[50] Once the power is registered, the Court of Protection may give directions upon the management of the estate and can require information about accounts and records.[51] It can also cancel the power if the attorney is considered "unsuitable".[52] The 1985 Act was designed[53] to overcome

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47. Continued
conference reported in Action Baseline No.30,(1985); "The Court of Protection Rules 1984", [1984] L.S.Gaz. 588.

48. Enduring Powers of Attorney Act 1985, s.1.

49. Ibid., s.3(1).

50. Ibid., s.4(2)-(6).

51. Ibid., s.8; these directions are of limited scope, see para. 3.13 below.

52. Ibid., s.8(4)(g).

the previously widespread problem of donees of ordinary powers of attorney continuing to operate them invalidly after the onset of the donor's incapacity, either in ignorance of the law, or because they feared the intrusion, expense and delay thought to result from an application to the Court of Protection for the appointment of a receiver.

3.11 It has been held that a donor is capable of creating a valid enduring power of attorney provided that he understands in broad terms the nature and effect of the document at the time when he executes it, notwithstanding that he is at that time incapable by reason of mental disorder of managing his property and affairs within the terms of the Mental Health Act 1983, and is accordingly personally unable validly to carry out the transactions which he is authorising his attorney to perform on his behalf.[54]

3.12 Although the introduction of enduring powers of attorney has provided a useful addition to the powers available to act on behalf of mentally incapacitated people, and was innovatory in granting power to license certain things in advance, there remain some inherent difficulties. The first is that attorneys have no duty to take positive steps to initiate action on behalf of their principal. Their role is essentially reactive, rather than proactive. Secondly, the scope of an enduring power of attorney is limited to dealing with "property and affairs"[55] and it

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53. The Incapacitated Principal, (1983), Law Com. No.122, Cmnd. 8977.

54. Re K., Re F. [1988] Ch. 310.

55. Enduring Powers of Attorney Act 1985 s.3(1). Cf. the position in New Zealand where the Protection of Personal and Property Rights Act 1988, ss.95-106 provides for an

cannot be used in any other area. Thirdly, any such device is a compromise between the need for a simple, effective and inexpensive method of allowing powers to continue despite incapacity and the need to protect the donor from exploitation. So far there has been too little experience to judge whether the present balance is right.[56] The experience abroad has been mixed. In British Columbia, the enduring power of attorney has apparently operated for ten years to everyone's general satisfaction,[57] whereas in Victoria, Australia, major problems have been revealed.[58] These issues have been addressed in a recent Discussion

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55. Continued
enduring power of attorney to extend to personal guardianship matters, subject to the safeguards which govern a personal guardianship order. The Australian Law Reform Commission has proposed a similar arrangement for the Australian Capital Territories. Third Report, No. 47, Enduring Powers of Attorney (1988).

56. The Lord Chancellor's Department has commissioned research into the operation of enduring powers of attorney from the Faculty of Law at Bristol University which may present some useful information on this subject.

57. Law Reform Commission of British Columbia, Report on the Enduring Power of Attorney: Fine-Tuning the Concept, (1990).

58. In a survey of 26 enduring powers of attorney in Victoria, Australia, 25 documents were found to be invalid. Guardianship and Administration Board, Annual Report 1987/88 Vic. Gov. Pr., 35. Also, the 1988 Annual Report of the Office of the Public Advocate, at p.56, refers to his numerous investigations into enduring powers of attorney and says "the picture is a sorry one. There are repeated stories of relatives coming to nursing homes in the middle of the night to obtain signatures on an enduring power of attorney, where the donor's capacity to give such power is in doubt. On the other hand, suggestible donors may sign and revoke powers at the request of relatives, or attorneys can intermingle a donor's assets with their own either through ignorance or malevolence. There have been many examples of attorneys denying donors access to their money during their lifetimes, sometimes resulting in the enlargement of the donors' estates when they die".

Paper released by the Law Reform Commission of Victoria,[59] but the different experiences of British Columbia and Victoria beg the question whether the present structure of the law in Victoria is largely responsible for allowing these abuses to occur, or whether the existence of a particularly efficent watch-dog in the person of the Public Advocate is uncovering abuses which go unnoticed elsewhere.

3.13 Although the formalities for the execution of an enduring power in this country are arguably more stringent than in some other jurisdictions,[60] it is possible that these operate at the wrong time, as the main dangers of exploitation occur not at the time of registration, but either at the time of execution or in later years, after the onset of the donor's incapacity. The execution of an enduring power of attorney represents a considerable act of trust in the attorney, for despite the supervisory powers of the Court of Protection, the court is unable to direct the attorney in how to exercise his discretion; it cannot, for example, entertain an application for the attorney to make payments to a third party in recognition of a moral obligation in the way that it could under a receivership.[61]

3.14 An enduring power can validly be granted only by someone who has sufficient capacity at the time of execution. It is therefore likely to be of particular

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59. Law Reform Commission of Victoria, Discussion Paper 18 Enduring Powers of Attorney, (1990).

60. e.g. the detailed registration requirements in the Enduring Powers of Attorney Act 1985, ss.4-7. See also the Enduring Power of Attorney (Prescribed Forms) Regulations 1990, S.I. 1990/1376.

61. Re R. (Enduring Power of Attorney) [1990] Ch. 647.

value to the elderly, but only if they are properly advised and the need is perceived in time. It will be of no use to people with mental handicap who have never had the capacity to execute such a document, or to people who are, for example, unexpectedly brain damaged in an accident. Further, the legislation does not attempt to resolve the problem of determining the exact time of the onset of incapacity, which can be particularly difficult to establish in cases of senile dementia, where use of the enduring power is likely to be most frequently encountered. Problems can also arise in the course of transition from one legal status to another, that is from competence to incompetence. Not only may it be impossible for practical reasons to establish with any precision the time at which this transition occurs, but as soon as the attorney has reason to suspect that the donor has become or is becoming mentally incapable and the need to register the power with the Court of Protection arises, the power lapses for most purposes until the registration procedure and other necessary formalities have been completed.[62] If, for any reason, there is a dispute about the validity of the power, or the incapacity of the donor, the power may be suspended for some time until the Court has adjudicated on the matter. The costs of these procedures will generally fall on the estate of the donor.

(c) Appointees

3.15 A special procedure is available[63] whereby the Secretary of State for Social Services can appoint another person to receive and deal with any income support or social

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62. Enduring Powers of Attorney Act 1985, s.1(1),(2).

63. Social Security (Claims and Payments) Regulations 1987, reg. 33. S.I. 1987/1968.

security benefits payable to someone who is "unable to act", and consequently cannot manage his own affairs. This procedure does not apply when the beneficiary's affairs are subject to the jurisdiction of the Court of Protection. It is, however, quite widely used; in 1984, for example, there was an estimated yearly total of over 45,000 cases.[64] This is clearly a necessary and sensible provision, allowing a mentally incapacitated person's benefits to be administered cheaply and easily, but there is no monitoring of the appointee. The system is accordingly wide open to abuse. Despite official guidelines warning against the appointment of staff or proprietors of homes or hostels in view of the danger of a conflict of interest; this still occurs, not infrequently because of the lack of any other available person. When such people are appointed, there is no obligation on them to keep records of receipts or any form of accounts. Although the D.S.S. has power to revoke the appointment immediately if it becomes aware that the appointee is unsuitable, there will, in most cases be no-one in a position to "blow the whistle", as the beneficiary is by definition unlikely to understand what is going on, or be in a position to complain.

3.16 Money due to someone who is unable to manage his property and affairs because of mental disorder may in certain circumstances be paid to someone else or applied on his behalf by virtue of several statutory powers without the need to invoke the jurisdiction of the Court of Protection.[65] These are principally concerned with the

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64. Age Concern, The Law and Vulnerable Elderly People, (1986), p.104. Enquiries of the D.S.S. have revealed that more recent figures are not available, but that in 1988, 1% of all benefits were paid to appointees.

65. e.g. Mental Health Act 1983, s.142(1),(2); Local Government Act 1972, s.118 as amended by Mental Health Act 1983, s.148, Schedule 4, para. 32; Clergy Pensions

periodic payment of pay or pensions to employees or former employees of local or central government, and allow payments to be made to the institution or person having care of the patient, to or on behalf of the patient's dependants, in repayment of any money spent on the patient's behalf or in payment of his debts.

(d) Supervisory powers of the court in litigation

3.17 Order 80, Rules of the Supreme Court 1965 and Order 10, County Court Rules 1981 contain special provisions governing the participation in legal proceedings of people under a legal disability. The same definition of mental incapacity is used as that invoking the jurisdiction of the Court of Protection under Part VII of the Mental Health Act 1983, namely that the person concerned must be incapable by reason of mental disorder of managing and administering his property and affairs. Other rules under these Orders provide special protection by preventing the progress of any action by or against a patient without the appointment of a next friend or guardian ad litem.[66] The rules also provide that no money claim made against or on behalf of a patient can be settled or compromised without the specific approval of the Court,[67] and set out detailed procedures to be followed regarding the handling and investment of any money recovered.[68] Whilst these rules may be well intentioned, in practice they can prove cumbersome and restrictive, for

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65. Continued
Measure 1961, s.36; International and Provident Societies Act 1965, s.26.

66. R.S.C. O.80 rr.2,3,6; C.C.R. O.10 rr.1-3.

67. R.S.C. O.80 rr.10, 11; C.C.R. O.10 r.10.

68. R.S.C. O.80 r.12; C.C.R. O.10 r.11.

example, by creating a delay before a patient can gain any benefit from an award of damages, although a practice note has recently been issued in an attempt to overcome these problems.[69]

Personal Care, Welfare and Medical Treatment

(a) Compulsory admission to hospital under Part II Mental Health Act 1983

3.18 These provisions were extensively reviewed during the 1970s and amending legislation passed in 1982.[70] They will not be reconsidered during this review. Nevertheless their existence and use is relevant, and they are mentioned here if only to demonstrate the circumstances in which and patients for whom they are not used. Procedures under the Act provide for compulsory admission to hospital for assessment for up to 28 days,[71] admission for treatment for up to six months[72] and admission in an emergency for up to 72 hours,[73] generally only on application by an approved social worker or the patient's nearest relative supported by

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69. Practice Note (Mental Health: Transfer of Damages) [1991] 1 W.L.R. 2.

70. L. Gostin, A Human Condition: The Mental Health Act from 1959 to 1975, Vol.1, (1975); Report of the Committee on Mentally Abnormal Offenders, Cmnd 6244, (1975); D.H.S.S., A Review of the Mental Health Act 1959, (1976); D.H.S.S., Review of the Mental Health Act 1959, Cmnd. 7320,(1978); Mental Health (Amendment) Act 1982.

71. Mental Health Act 1983, s.2.

72. Ibid., s.3.

73. Ibid., s.4. Emergency admission requires only one medical recommendation but may be converted into an admission for assessment by the provision of a second recommendation within 72 hours.

recommendations from two doctors, one of whom must be an approved specialist. Most detained patients can be given most forms of treatment for their mental disorder (but not for other conditions) without their consent.[74] Discharge from hospital is generally by a doctor,[75] a Mental Health Review Tribunal[76] or, in long term cases, by the patient's nearest relative.[77]

3.19 However, well over 90% of admissions to mental hospitals are now on an informal basis.[78] This is probably because, in practice, compulsion is only needed when a patient actively refuses to cooperate with the treatment or care which his doctors or other professionals consider that he needs for his own sake or for the protection of others. Compulsory powers are used much more frequently in relation to mentally ill patients than to people with a mental handicap.[79] Active resistance often (but not always) arises as a result of a mentally ill patient's lack of insight into his condition or as part of his delusional

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74. See paras. 2.14, 2.25 above.

75. Mental Health Act 1983, s.23.

76. Ibid., ss.72-75.

77. Ibid., ss.23, 25.

78. In 1986, only 7% of admissions in England were under compulsory powers in the Mental Health Act 1983. D.H.S.S., Mental Illness and Mental Handicap Hospitals and Units in England: Legal Status Statistics 1982-86. There were a total of 197,251 admissions to mental hospitals. D.H.S.S., Mental Health Statistics for England 1986. In the same year, 396 patients were discharged by orders of Mental Health Review Tribunals. D.H., unpublished statistics.

79. Between 1 July 1987 and 30 June 1989, compulsory powers under the Mental Health Act 1983 were invoked a total of 7154 times in respect of mental illness, 113 times in respect of psychopathic disorder and 408 times in respect of mental impairment. Mental Health Act Commission, Third Biennial Report 1987-1989, p.27.

system. It is rarer in the case of mentally handicapped or elderly people, and there is an understandable reluctance to stigmatise them as in need of compulsory hospitalisation when legal compulsion is, in fact, rarely necessary. This also means that mentally disordered people who are unable to express a view one way or another are generally admitted informally. Thus informal admission is not the same as voluntary admission in the sense of being the result of real and informed consent. The Mental Health Act Commission has on several occasions drawn attention to the problems of obtaining consent to treatment from such patients and expressed concern about the de facto detention of patients who are not admitted under compulsory powers.[80]

(b) Emergency powers

3.20 Apart from compulsory admission and guardianship under Part II Mental Health Act 1983, there are two main legislative provisions giving power to intervene compulsorily to remove a vulnerable adult from his home in an emergency and place him in institutional care. The first is Mental Health Act 1983, section 135, under which an approved social worker may apply to a magistrate for a warrant to search and remove from premises to a place of safety any person believed to be suffering from mental disorder whom there is reasonable cause to suspect has been illtreated, neglected or kept other than under proper control or, being unable to care for himself, is living alone. A patient removed to a place of safety[81] under this

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80. Ibid., p.35. See also Mental Health Act Commission, First Biennial Report 1983-85, p.11 and Second Biennial Report 1985-87, p.50.

81. Place of safety is defined in s.135(6) as including residential accommodation provided by a local authority under Part III of the National Assistance Act 1948 or under para. 2 of Schedule 8 to the National Health

section may be detained, but not treated, for up to 72 hours. The period of detention may be used to consider the need for compulsory admission to hospital for assessment, treatment or guardianship. However, the criteria for such longer term intervention[82] are narrower than those in section 135, so that even if a person believed to be suffering from mental disorder is temporarily removed because of suspected abuse or neglect, it may not be possible to make suitable alternative arrangements for his treatment and care, because he may not meet the criteria for longer term detention under the Act. A similar power, not requiring a certificate from a magistrate, is provided in section 136 of the 1983 Act, whereby a police constable may remove to a place of safety for up to 72 hours, any person found in a public place who appears to him to be suffering from mental disorder and to be in immediate need of care and control.

3.21 Section 47 of the National Assistance Act 1948 provides that on the certificate of a community physician, the district local authority may apply to the magistrates court for a removal order. The person concerned must be suffering from grave chronic disease or being aged, infirm or physically incapacitated, be living in insanitary conditions, and be unable to devote to himself or not receiving from other people, proper care and attention. His removal from home must be necessary either in his own

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81. Continued
Service Act 1977, a hospital, police station, mental nursing home or residential home for mentally disordered persons or any other suitable place the occupier of which is willing temporarily to receive the patient.

82. Mental Health Act 1983, ss. 2,3,7-10,37-40; see also, P. Fennell, "The Beverley Lewis case: was the law to blame?", (1989) 139 N.L.J. 1557.

interests or for preventing injury to the health of, or serious nuisance to, other persons. The order will direct that person's removal from the premises in which he is residing to a suitable hospital or other place within a convenient distance, to "secure the necessary care and attention". The maximum period for such an order is three months,[83] but it can be renewed. A confusing division of responsibility can arise in non-metropolitan counties, where the district local authority is not the local social services authority responsible for the provision of domiciliary social services and running residential homes. Thus, the local authority may make an application to the magistrates court without the involvement of social workers who may have been helping the person concerned. Furthermore, the community physician himself is not an employee of either body, but of the health service.[84]

3.22 The National Assistance (Amendment) Act 1951 provides an additional emergency procedure where it is necessary to remove the person without delay. This is probably used more often than the full procedure, as they are both provisions of last resort and liable to be invoked only in cases of extreme urgency. The emergency procedure permits several short cuts: the order can be made ex parte, the application may be made to a single justice rather than the full court, the community physician may make the

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83. National Assistance Act 1948, s.47(4).

84. Those originally responsible for operating these powers were the Medical Officers of Health who were employed by local authorities in their health and welfare departments before the reorganisation of local government and the health service in the early 1970's. The present illogical division of responsibilities arose as a consequence of the effects of the Local Authority Social Services Act 1970 and the National Health Service Reorganisation Act 1973.

application himself, supported by a second medical opinion, and periods of notice required under section 47 may be waived. These powers are not confined to persons suffering from mental incapacity, but it is estimated that up to 50% of people dealt with under these sections are mentally disordered.[85]

3.23 These emergency powers are generally regarded as draconian and stigmatising, and are rarely used. The National Assistance Acts are particularly unpopular and some local authorities have a policy of refusing to use them.[86] There are obvious gaps in the legislation. For example, it could in some situations be difficult to use section 135 to intervene in the case of two incapable adults living in the same house, as they could not be said to be "living alone". Because applications under section 135 are made by social workers, and those under section 47 by community physicians, responsibility for taking emergency action does not lie clearly in any one place. There are likely to be differences in interpretation of the need for intervention, as section 135 is operated by people who specialise in dealing with mentally disordered people under the Mental Health Act, whereas section 47 may not be. People detained under section 135 are usually placed in a mental hospital, whereas those committed under section 47 tend to be sent to residential accommodation, provided under Part III of the 1948 Act, or to a nursing home. Although both procedures include elements of a judicial process, in requiring an application to be made to a magistrate or magistrates' court before any powers can be exercised, there is no provision for the patient to be represented. In the case of an

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85. Age Concern, op. cit., p.40.

86. S. Greengross, "Protection or Compulsion?", (1982) 6 J.R.S.H. p.240.

application under section 47, he has no right to apply for revocation of the order until a period of six weeks has elapsed. Despite the existence of a judicial process, the evidence presented is likely to be very much a matter of opinion for the professionals concerned. Terms such as "insanitary conditions" and "illtreatment or neglect" are difficult to define and depend ultimately on a value judgment based upon their own view of the correct balance to be held between the individual's right to live as he wishes, even if such wishes are delusionary or in most people's view extremely eccentric, and the need for protection from unnecessary suffering or danger. The criteria applied are also likely to vary considerably from place to place, and whether or not one of these emergency powers is used in a particular situation may depend on nothing more than where the person concerned happens to live.

(c) Guardianship under the Mental Health Act 1983, ss.7 - 10

3.24 Guardianship in its modern form was first embodied in the Mental Health Act 1959.[87] Guardianship had been seen by the Percy Commission as a device which would enable community care to be extended to all groups of mentally disordered people, and as a lesser and more appropriate form of intervention than detention in hospital for those with mild disorders.[88] Under the 1959 Act,[89] patients might be

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87. For an account of its development see M. Fisher, "Guardianship under the Mental Health Legislation: a Review" [1988] J.S.W.L. 316; and S. Millington, Social Work Monographs: Guardianship and the Mental Health Act 1983, (1989).

88. The Department of Health's view remains very similar today. The 1990 Code of Practice to the Mental Health Act 1983 defines the purpose of guardianship as "to enable patients to receive community care where it cannot be provided without the use of compulsory powers. It enables the establishment of an authoritative

received into the guardianship of a local social services authority[90] or of a private individual approved by them and subject to their supervision. A guardian had the powers which would be exercisable by the father of a child under the age of 14, which certainly included the power to consent to medical treatment, although the extent to which it included power to control the patient's spending or disposition of his property was less clear. However, it was never very frequently used, and the total number of people subject to guardianship slowly declined from 1133 in 1960 to 133 in 1978.[91]

3.25 The D.H.S.S. review of the operation of the 1959 Act[92] included an examination of the scope and purpose of guardianship. It considered three main options for reform:

(i) to retain guardianship in its existing form, with revisions to the criteria of applications and the inclusion of a specific power to consent to treatment;

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88. Continued
framework for working with a patient with a minimum of constraint to achieve as independent a life as possible within the community", para. 13.1, p.34.

89. s. 34.

90. Before the Local Authority Social Services Act 1970, this function was undertaken by local authority health and welfare departments.

91. D.H.S.S., A Review of the Mental Health Act 1959, (1976).

92. D.H.S.S., Review of the Mental Health Act 1959, Cmnd. 7320, (1978).

(ii) to create a new type of community care order, as proposed by the British Association of Social Workers;[93]

(iii) to reduce the guardian's powers to the minimum needed to secure medical treatment, social support and training and to require access.

The third option, the "essential powers" approach, was chosen, and changes to guardianship were enacted in 1982.[94]

3.26 An application may now be made for the appointment of a guardian if the patient suffers from any of the four specific categories of mental disorder within the meaning of the Act,[95] and guardianship is necessary for his own welfare or for the protection of others.[96] Applications have to be made to the local social services authority by an approved social worker or by the patient's nearest relative and supported by two doctors.[97] The guardian may be either the local authority or a private individual; but it is obviously not contemplated that the latter should be the patient's nearest relative or family carer, for unless replaced by a county court, the nearest relative can object

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93. In Mental Health Crisis Services - A New Philosophy, (1977), B.A.S.W. proposed that local authorities should have a statutory duty to provide resources to enable the exercise of guardianship powers, and that as an alternative to hospitalisation, new, compulsory powers be introduced to provide care, including medical treatment, in the community.

94. Now to be found in Mental Health Act 1983, ss. 7-10.

95. See para. 2.14 above and also para. 3.30 below.

96. Mental Health Act 1983, s. 7(2).

97. Ibid., ss.7(3), 11(1).

to the application or subsequently discharge the patient.[98] The powers of a guardian are much less extensive than under the 1959 Act as he has power only to require the patient to live at a specified place, to attend for medical treatment, occupation or training, and to require access to be given at any place where the patient is living to people such as doctors and social workers.[99] A guardian cannot compel the patient to undergo medical treatment without his consent, and guardianship patients accordingly have the same right as anyone else to refuse treatment. Guardianship initially lasts for six months, but may be renewed for a further six months, and thereafter annually.[100] People placed under guardianship have a right to apply to a Mental Health Review Tribunal.[101]

3.27 Under section 37 of the Mental Health Act 1983, a guardianship order may be made by a criminal court which considers it a suitable disposal after convicting a person of any offence punishable with imprisonment.[102] The medical criteria and effects of the order are the equivalent of those in civil guardianship, except that the patient's nearest relative has no power to discharge him.

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98. Ibid., ss.11(4),23(1),29.

99. Ibid., s.8(1).

100. Ibid., s.20.

101. Ibid., s.69(1)(b).

102. Apart from one for which the penalty is fixed by law; a magistrates' court may make the order in respect of a mentally ill or severely impaired person without convicting him, provided that it is satisfied that he did the act or made the omission charged; Ibid., s.37(3).

3.28 Although it was expected that the amendments incorporated in the 1983 Act would result in an increased use of guardianship, this expectation has not been realised, and guardianship is used as rarely as ever.[103] The Mental Health Act Commission has made efforts to encourage social workers to consider it more positively and statistics show that it has increased from 41 cases in 1982/3 to 120 in 1986/7.[104] This is still hardly more than minimal. There are a number of factors which probably help to explain this. Some are a consequence of the more restrictive conditions introduced in 1983, but others applied equally to guardianship in its 1959 form. These factors would never all arise in a single case, but in combination they amount to a significant obstacle to regarding guardianship as a useful and relevant procedure.

3.29 The stigma of a formal finding of mental disorder on an application for guardianship discourages relatives and social workers and makes them reluctant to invoke a procedure by which the patient is officially labelled incapable. The paternalistic aspects of the authority under the 1959 Act were particularly contrary to modern social work thinking and practice, and the negative view engendered of guardianship as embodied in the Mental Health Acts has resulted in lack of use becoming a "self fulfilling prophecy".[105]

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103. Fisher, op. cit., at pp.323-4 concludes on the basis of a study conducted by the Social Services Research Group that the use of guardianship since 1983 is "clearly very low" amounting to less than 200 uses over a one year period, and that it is not currently a primary means of diverting people from compulsory admission to hospital.

104. Mental Health Act Commission, Third Biennial Report 1987-1989, p.48.

105. M.J. Gunn, "Mental Health Act Guardianship: Where Now?", [1986] J.S.W.L. 144.

3.30 The changes in the 1983 Act restricted the categories of mentally handicapped people who could be received into guardianship. Thus, unless the patient is mentally ill or psychopathic, he must be suffering from "mental impairment". The legal definition of this now requires the presence of "abnormally aggressive or seriously irresponsible conduct" in addition to severe or significant impairment of intelligence and social functioning.[106] This means that guardianship cannot be used to help the great majority of mentally handicapped people whose behaviour does not fall within this definition,[107] and there may be reluctance to use it where uncertainty exists. It is, for example, difficult to know quite what is meant by "seriously irresponsible". Must such conduct be in relation to others, or can people be seriously irresponsible towards themselves if it is simply beyond their capabilities to look after themselves properly? At the time these provisions were being debated in Parliament, there was considerable pressure, largely from MENCAP,[108] to have mental handicap unassociated with psychopathic behavioural problems removed from the scope of the compulsory powers.[109] However, this seems to have been done mainly with hospital admission in mind. The repercussions of this upon the scope of

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106. Mental Health Act 1983, s.1(2); see para. 2.14 above.

107. Gunn, op. cit., at p.148 concludes that "this causes guardianship to fail in one of its major functions and would appear to fly in the face of the expectations of government, and presumably, Parliament." He advocates rectifying the situation by replacing the four specific forms of mental disorder in Mental Health Act 1983 s.7(2)(a) with the simple term "mental disorder".

108. e.g. Lord Renton in the Mental Health (Amendment) Bill debate, Hansard (H.L.), 1 December 1981, Vol.425, cols. 970-4, 1007.

109. R. Bluglass, "The Origins of the Mental Health Act 1983: Doctors in the House", Bulletin of the Royal College of Psychiatrists, (1984), p. 127, 131.

guardianship may not have been properly foreseen or considered.

3.31 The duties of a guardian and of the local social services authority when guardianship is undertaken are governed by the Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983.[110] The guardian must be either a local social services authority or a person approved by them, and there is provision for fairly close supervision by social services; guardianship therefore operates as a social services function and a form of state intervention, rather than a means of legitimising private arrangements and encouraging relatives to undertake formal responsibilities. This is in contrast to the operation of the Court of Protection which, at a price, legitimises the role of the private individual receiver and appoints the Public Trustee to act as "state" receiver only in the last resort.

3.32 Guardianship is essentially a social services function, and local authorities are quite free to decide not to accept an appointment. Apart from possible philosophical objections to the concept of guardianship itself, there are also likely to be resource considerations involved. Most facilities for mentally handicapped people, in or out of hospital, have traditionally been provided by the National Health Service. The transfer of resources to local authority social services departments is proving slow to achieve.[111] The Mental Health Act Commission's initial

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110. S.I. 1983/893.

111. e.g. Audit Commission, Making a Reality of Community Care, (1986), chs. 1,2. Also, the Government's recent decision to defer until 1993 the implementation of plans for community care.

conclusion, that some social services departments are reluctant to use guardianship because of the demands it is likely to make on residential facilities or staff time,[112] was confirmed in its latest report.[113] The necessity of spending money in order to provide a decent community based service for the mentally disordered has been recognised by government.[114] But where there is competition for resources, areas like guardianship in which local authorities have statutory powers as opposed to duties,[115] are likely to be given a lower priority.[116]

3.33 There is also the argument that in practice the vast majority of services can be provided just as easily without guardianship; there is little point in local authorities troubling with legal formalities which confer no particular advantage. There are no effective legal sanctions if the patient fails to observe the requirements of his guardian. It is practically impossible to force someone living in the community to live in a certain place

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112. First Biennial Report 1983-85, para. 8.5(a)(iii), p.21.

113. Third Biennial Report 1987-89, para. 12.7, p.48 which says "The Commission has been particularly concerned about a number of cases drawn to its attention where a Mental Health Review Tribunal's recommendation that a detained patient be transferred into guardianship has been thwarted by the Local Authorities' unwillingness to accept the patient".

114. D.H.S.S., Government Response to the Second Report of the Social Services Committee: Community Care, (1985); Caring for People: Community Care into the next decade and beyond, Cm.849, (1989).

115. National Health Service Act 1977, Schedule 8 para. 2(1)(d) as substituted by the Mental Health Act 1983, s.148, Sch. 4, para. 47(e)(ii).

116. P. Bean, Mental Disorder and Legal Control, (1986), pp.78-83.

or attend a training centre against his wishes. Most social services departments would not have the resources continually to monitor the situation, and there is accordingly little to stop the person under guardianship from ignoring its provisions, if he feels inclined to do so.[117] As guardianship is only likely to be effective if the patient's voluntary cooperation is obtained, albeit with an element of "persuasion", this leads to the fundamental contradiction that compulsion is not required at all if the compliance necessary to make guardianship effective stems from consent.[118] If this is so, it could reasonably be argued that the only positive effect guardianship has is a fairly unpredictable psychological one, and it is questionable whether this is a legitimate or desirable purpose. We are aware, however, of some social workers who feel able to use the provisions imaginatively and constructively to provide a framework within which proper services can be obtained for the patient and accepted by him.

3.34 Another possible use of guardianship might be to protect a mentally incapacitated person from a neglectful or exploitative relative, or one who is unable to care for him, but it is not well adapted for this purpose. There is doubt about how far it can apply to mentally handicapped people with no severe behavioural problems.[119] There is no short term emergency procedure, as there is for hospital

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117. This is recognised in para. 13.7 of the Code of Practice (1990) to the Mental Health Act 1983 "if the patient continually resists the exercise of the guardian's powers it can be concluded that guardianship is not the most appropriate form of care for that person and the guardianship order should be discharged".

118. Gunn, op. cit., at p.149.

119. See para. 3.30 above.

admission.[120] Above all, no application for guardianship can be made by a social worker if the patient's nearest relative objects.[121] An application may be made to a county court for the removal and replacement of the nearest relative usually on the ground that he is unreasonably objecting to the application being made, although an alternative ground is that he is incapable by reason of mental disorder or other illness from acting as nearest relative.[122] Such an application takes time and it is in just those cases where the nearest relative is neglectful or exploitative that such difficulties are likely to arise and urgent action is most likely to be needed.[123] In effect, the nearest relative has an initial right of veto, and it is not possible for guardianship to begin or continue pending the disposal of an application to replace the nearest relative.[124] Accordingly, guardianship is inherently unsuitable either as an emergency procedure or to provide long term protection against neglect or abuse in the patient's own home. The alternative, short term provisions tend to be used instead,[125] to which the nearest relative's right of veto does not apply.

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120. Mental Health Act 1983, s.135.

121. Ibid., s.11(4).

122. Ibid., s.29(3)(b), (c).

123. P. Fennell, "The Beverley Lewis case: was the law to blame?", (1989) 139 N.L.J. 1557.

124. cf. Mental Health Act 1983, s.29(4) which extends the period of detention under s.2 (admission for assessment) where, before its expiry an application has been made to replace the nearest relative because he is unreasonably objecting to the application for admission for treatment, or is seeking to exercise his power to discharge the patient without due regard to the patient's welfare or the interests of the public.

125. See para. 3.18 above.

(d) The Royal prerogative

3.35 It has sometimes been suggested,[126] that the prerogative jurisdiction[127] should be restored by the Queen reissuing a Royal Warrant under the Sign Manual, particularly so as to enable the judges to give consent to medical treatment on behalf of an incapable patient. If available this could, of course, cover many types of decision. However, the House of Lords in Re F [128] accepted that the jurisdiction no longer existed, Lord Brandon expressing the view that it had been swept away by a combination of Mental Health Act 1959, section 1 and the revocation of the Royal Warrant. Although their lordships did not directly say that the jurisdiction is now incapable of being revived, there is a tenuous argument that, as the 1959 Act appeared to cover all the ground which had been covered by the prerogative, the prerogative itself had been abrogated and could not be revived by the modifications in the 1983 Act, despite the fact that it had not been expressly abolished by legislation.

3.36 If this argument is not accepted, there would still be serious difficulties in reissuing the Royal Warrant so as to enable the jurisdiction to become a practical solution to the problem of consent to treatment.[129] The old "common law" procedure for inquisition by jury was progressively modified

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126. e.g. by Wood J. in T. v. T. [1988] Fam. 52.

127. See paras. 3.2 and 3.3 above.

128. [1990] 2 A.C. 1; see paras. 2.20-2.24 above.

129. B. Hoggett, "The Royal Prerogative in relation to the Mentally Disordered: Resurrection, Resuscitation or Rejection?", in M.D.A. Freeman (ed.), Current Legal Problems: Medicine, Ethics and the Law, (1988), p.85.

by legislation over several hundred years.[130] These statutes have all now been repealed, and it can hardly be appropriate to use the prerogative either in its original mediaeval form or without any of the former safeguards, to interfere with the liberty or property of the subject at the turn of the twenty-first century. It would be necessary to devise appropriate procedures and a test to establish incapacity. There are no clear and obvious criteria, as in the application of wardship to minors. If, as the historical evidence suggests, the assumption of power by the committee of the person was total, is this an appropriate model for the twenty-first century, and is it necessary when in most cases all that will be required is a solution to a particular problem? There would also be numerous practical problems. Would the High Court have to make all decisions on behalf of mentally incapacitated people, or at least, appoint a committee of the person for them? If so, the burden on the court would be enormous and entirely unrealistic.

(e) Applications to the High Court for a declaration

3.37 As we have seen in Part II,[131] the declaration procedure has recently been adopted in a series of cases where a mentally incapacitated adult has been unable to give a valid consent to medical treatment.[132] The court has been asked to declare that sterilisation operations or abortions would not be unlawful by reason only of the patient's lack

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130. See para. 3.2 above.

131. See paras. 2.20-2.24.

132. Practice Note (Official Solicitor: Sterilisation) [1989] 2 F.L.R. 447; Practice Note (Mental Patient: Sterilisation) [1990] 1 W.L.R. 1248.

of consent.[133] From a practical point of view, the protection afforded to doctors by a declaration is only partial, as although it would be effective to avert a civil action for damages, it would provide no defence to criminal proceedings.[134] The desirability of piecemeal decision-making through caselaw is questionable. Decisions of the courts, particularly in sensitive areas, tend to be confined to the particular facts, and there is a reluctance to give pronouncements on principles of general application. This can mean that there is no real consistency between different decisions, and make it difficult to elicit guidelines with any real reliability. Also in doubt is the need for such an expensive and potentially intimidating procedure which, whilst it might more easily be justifiable in relation to matters such as sterilisation, will not adapt readily to less serious matters upon which decisions still need to be made, usually with much greater frequency and urgency.

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133. e.g. Re T., unreported, 14 May 1987, Latey J; T. v. T. [1988] Fam. 52; Re F. [1990] 2 A.C. 1; see paras. 2.20-2.24 above.

134. Imperial Tobacco Ltd. v. Attorney General [1981] A.C. 718, per Viscount Dilhorne at p. 741; per Lord Lane at p. 752. See also Hoggett, op. cit., p.87.

PART IV

THE POLICY ISSUES

4.1 In this Part, we identify the main defects in the present law and discuss the broad approach which might be taken in any attempt to devise workable and acceptable reforms. We also outline some of the principles which have gained broad international acceptance in reforms which have taken place elsewhere. Some of those reforms will be explained in Part V before we go on to discuss specific options for reform in Part VI.

Principal Defects of the Present Law

(a) Fragmentation

4.2 The existing law has been developed ad hoc to meet particular needs. This has resulted in a variety of different procedures and mechanisms, each for a particular purpose; some of these work better than others, but taken together, they do not form a coherent system and have serious shortcomings. In some areas of decision-making, for example, decisions upon matters such as accommodation or relationships, there are no legal procedures at all.[1] In others, the law operates so unsatisfactorily or inadequately that it is either ignored or rarely used,[2] or has such inappropriate effects that efforts are made to avoid it.[3] As a consequence, the decision-making process is largely

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1. See particularly para. 1.9(ii),(iii) and (v) above.

2. See, for example, paras. 3.23 and 3.28 above.

3. e.g. the potential financial consequences for a comparatively small estate of the involvement of the Court of Protection. See para. 3.8 above.

unregulated and is open to exploitation and abuse. At times, decisions which need to be made may not be made at all, or may be made too late. If this is so, the law is frequently failing the very people it is intended to help and protect.

4.3 For mainly historical reasons, a division exists between the care of a mentally incapacitated person's property and affairs, and his personal care. Whilst this may be practical in some respects, it is also somewhat artificial, and can create problems. For example, how is it possible in practice for a guardian who has no control over the patient's finances to make a meaningful decision about where he should live? The power to decide upon someone's place of residence must necessarily entail knowledge of his financial resources and some degree of control over them. Equally, a receiver, who strictly speaking has no authority to direct where a patient lives,[4] may effectively control this by selling or purchasing a property, or by refusing to pay nursing home fees. In practice, the extent of the problem is masked by the availability of means-tested benefits to pay for residential care.[5] However, the division into person and property was established at a time when people fell more neatly into categories of "rich" or "poor" than they tend to do today. The expansion of pension schemes and home ownership has meant that there are many more people with "middling means"[6]

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4. Because under Mental Health Act 1983, s.99(2) the receiver's authority is limited to the patient's "property and affairs"; Re W.(E.E.M.) [1971] Ch. 123.

5. The effect of the transfer of resources and responsibility from social security to social services under the National Health Service and Community Care Act 1990 must also be taken into account.

6. See para. 2.7 above.

which can either be used to enhance their lives now, or be inherited by their children. Strict separation of stewardship of property and guardianship of the person may no longer make sense.

4.4 From the point of view of carers and professionals, the division of responsibility for mentally incapacitated adults is often unclear. Many people have some responsibility in some circumstances, including hospital doctors, general practitioners, other health care workers, social workers, parents, guardians, receivers, nearest relatives, and lawyers, but the boundaries between them are vague and may either overlap or leave gaps. A corollary of this is that there is no identifiable residual responsibility for a mentally incapacitated person when, for example, the surviving parent of a mentally handicapped child dies or becomes too old to continue to look after him. The problem of "what will happen when I am gone" is a source of much anxiety for many carers. Similar problems can occur during periods of transition in life. There are, for example, often disputes between various agencies about who should take on responsibility for meeting the needs of a mentally incapacitated young adult as he attains his majority. There is no formal mechanism for resolving such disputes, which can last for a long time, causing considerable uncertainty and sometimes, despair.[7] The result is that conscientious carers and professionals are often left to do the best they can without any guidance, and without any certain protection against allegations of malpractice, or of exceeding their authority.

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7. e.g. N. Fielding, "Can't pay, won't pay to care for Denise", The Independent, 9 July 1990, p.14.

4.5 It can be argued that, if a functional view of capacity is adopted, this necessarily requires different techniques to be used for identifying capacity in different circumstances, and some degree of fragmentation in the law is inevitable. Nevertheless, the legal institutions for dealing with the problem need not be fragmented. These could be designed as a unified structure, providing a coherent framework into which these different techniques might fit. The provision of such a legal framework would also assist carers and professionals by providing the machinery to resolve problems, including some of those mentioned above, to which the law cannot be expected to provide an automatic solution.

(b) Existing procedures are not used

4.6 In several areas, powers exist but are not used, either because of the stigma perceived to attach to them or because they are seen as inappropriate or unnecessary. Family members prefer not to have to label their elderly relatives as "incapable of managing their property and affairs" if they can possibly cope without doing so. This is particularly the case if the legal procedures, such as those of a receivership application or the registration of an enduring power of attorney, require notice of the application to be served on the person concerned. As long as that person retains some degree of understanding, service and explanation of the notice, if carried out properly, will be seen as a distressing experience for all concerned. If the person concerned is no longer capable of understanding, it is seen as an irritating irrelevance. Yet this entitlement to notice is a basic civil right, and can be an essential safeguard against abuse or bad faith.

4.7 The Mental Health Act itself reflects a preference for voluntary or informal, rather than compulsory, admission to hospital whenever possible.[8] This is intended to cater, not only for the genuinely consenting but also for the merely non-resisting, a category into which many of the people with whom we are now concerned will fall. The compulsory powers in the Mental Health Act, although designed to be as simple, private and non-stigmatising as possible, are both in law and in practice reserved for those who have to be compelled. For what may be very good, practical and humane reasons, important decisions may be taken on behalf of mentally incapable people with none of the safeguards which would be available if they or their families were actively opposed.

4.8 There may also be a reluctance (which may sometimes be attributable to a lack of knowledge and understanding) to use compulsory powers even when they are both necessary and appropriate.[9] This may have contributed to tragedies like the case of Beverley Lewis,[10] as it is arguable that existing statutory powers could have been used to gain access to Beverley, but were not.[11] Guardianship is hardly used, partly for these reasons.[12] It is also possible that sterilisation operations have sometimes been carried out on mentally incapacitated women without seeking permission from

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8. Mental Health Act 1983, s.131(1); see para. 3.19 above.

9. Mainly National Assistance Act 1948, s.47. See paras. 3.17 and 3.18 above and S. Greengross, "Protection or compulsion?", [1982] J.R.S.H. 240.

10. See para. 1.9, n.15 above.

11. P. Fennell, "The Beverley Lewis Case: was the law to blame?", (1989) 139 N.L.J. 1557.

12. See para. 3.28 above.

the High Court, perhaps because everyone concerned is agreed that it is the right course, perhaps because they have never heard of Re F., or perhaps (if they have heard of it) because they fear the expense, delay, and intrusion such an application might involve.[13]

(c) Procedures for identifying incapacity are inadequate

4.9 The law has not developed a clear means of identifying mental incapacity for legal purposes. Where legal tests of incapacity exist[14], they differ; they also tend to be inaccessible, and sometimes incomprehensible, to the layman. As a consequence, it is often impossible in borderline cases to assess in advance whether an individual has capacity in relation to a particular transaction. There is no clear, statutory formulation, establishing workable and readily accessible tests of incapacity, together with a means of operating them in relation to particular circumstances and individuals. In practice, decisions about incapacity have to be made by professionals or carers without any clearly laid down test or procedural safeguards.

Possible Approaches to Reform

4.10 Any attempt at law reform needs to start with a clear idea of what it is realistic to try to achieve. It

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13. F. Scroggie, "Why do parents want their children sterilised? A broader approach to sterilisation requests", [1990] J.C.L. 35,36. But see D.H., A guide to consent for examination or treatment, (1990) and Circular HC(90)22 which now make the position quite clear.

14. See paras. 2.14-2.31 above.

is necessary to recognise that there are tensions and problems, particularly in this area, which no amount of law reform can ever fully resolve. The law has to be seen in the context of the society in which it operates, and many problems to which law reform is sometimes seen as a likely solution (such as the prevention of tragedies like the death of Beverley Lewis[15]) are bound up with questions of broad social policy, professional practice and ethics and the provision of resources and services. The law can, however, facilitate the resolution of problems which face mentally incapacitated people and their carers by providing a comprehensive set of rules and procedures appropriate to their differing needs, within a flexible framework. On the assumption that reform is needed, an important preliminary question is how the task should be approached.

(a) Which is the best broad approach?

(i) The minimalist

4.11 One approach might be a general "tidying up" exercise, aimed at removing the main anomalies and obstacles and encouraging a greater use of existing provisions without any wholesale revision of the law. A typical example might be extending the categories of mentally disordered people who may be subject to guardianship.[16] The main advantage of this approach would be speed, in that it would be most likely to be the first to show positive results, but there would also be serious drawbacks. It would not permit proper consideration to be given to areas in which the law

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15. See para. 1.9(iv), n.15 above.

16. See para. 3.30 above.

does not operate at present.[17] It would preclude the introduction of new models for decision-making which might be better suited to meeting the needs of mentally incapacitated people in the twenty-first century. At worst, it would be little more than a temporary "stop gap" to deal with the most pressing problems, and would only postpone the need for a more comprehensive review.

(ii) The incremental

4.12 An alternative would be separately to examine particular areas, or particular kinds of problem, with a view to up-dating, or if necessary thoroughly reforming, the law on that subject. Suitable topics would, for example, be consent to medical treatment, emergency crisis intervention or protection against abuse and neglect, the development of delegated decision-making in the form of enduring powers of attorney or "living wills"[18] or the reform of financial management. This approach could provide long term solutions to many problems. The main disadvantage would be a tendency to look at each problem in isolation, which might result in insufficient attention being paid to matters such as advocacy,[19] which straddle the entire subject. It has also been suggested[20] that this approach might have the effect of limiting the enquiry to an examination of particular legal problems to the exclusion of related ethical and social criteria. These dangers could, however, be minimised by acknowledging their existence and keeping them constantly in mind, and by having an overall plan which provides for an incremental revision of the law

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17. See para. 4.2 above.

18. See para. 6.5 below.

19. See paras. 6.47-6.48 below.

20. By the Law Society's Mental Health Sub-Committee.

and practice by reforms which are complementary, rather than separate.

(iii) The overall

4.13 The final option would be a full long term investigation into all aspects of decision-making on behalf of mentally incapacitated adults with a view to recommending the creation of a comprehensive code of law and practice aimed at providing a solution, at an appropriate level, to all problems which are likely to arise. This could include, but would not necessarily be limited to a new statutory guardianship scheme similar to those recently adopted in a number of commonwealth countries.[21] This would be a protracted process, and might take some years to reach fruition. It would be necessary to be alert to the danger of creating large and unwieldy machinery which is too complicated and inflexible to respond to urgent needs; subject to this, however, an approach along these lines would have the advantage of coherence and could more easily encompass new ideas and models which do not fit comfortably into existing procedures.

(b) Formalities versus informality

4.14 We have already referred to the apparent reluctance felt by professionals and carers to invoke legal machinery.[22] Their reasons for this deserve every respect. It would certainly be a reversal of the whole trend of legal development in this century to insist on legal formalities being employed whenever serious decisions were

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21. See Part V below, particularly paras. 5.4-5.12.

22. See paras. 4.6, 4.7 above.

taken on behalf of mentally incapacitated people. Nevertheless, there is a case for a greater use of formality than there is at present.

4.15 One consequence of the reluctance to use legal powers is that patients are deprived of the procedural safeguards they contain.[23] For example, the difficulty with the "voluntary" removal of a mentally incapacitated person from his home into institutional care is that, even if he acquiesces physically, there is no genuine consent. Whatever their shortcomings, the use of compulsory powers under, for example, the National Assistance Act 1948 does at least give a right to apply to court after six weeks for the order to be revoked. Compulsory admission to hospital carries a right of application to a mental health review tribunal, periodic reviews and control over certain types of treatment. "Voluntary" removal from home carries no rights of appeal at all. Whilst humane informal action may often be what is in the best interests of the person concerned, the assumption that informality is often preferable to legal authority can be accompanied by an all-or-nothing approach, in which more authority is in fact assumed than is warranted by the person's individual capacities and circumstances. There is then little incentive to maximise the capacities he does have or to encourage him to take his own decisions to the greatest extent possible.

4.16 The other main problem with the informal approach is that, whilst it may work well in the majority of cases in the context of a caring family supported by well motivated professionals, in a minority of cases it can make it easier for rogues to prey upon mentally incapacitated people with

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23. See para. 3.19 above.

less chance of discovery or intervention. Thus, the door may be left wide open to exploitation and abuse. The question then arises whether it is justifiable to impose potentially onerous legal formalities and duties for the sake of the minority of cases in which they may be valuable, when in the vast majority of cases they may neither be strictly necessary or wanted. There is an argument in favour of formal intervention in the affairs of mentally incapacitated adults up to a point, even where on the surface there appears to be no actual need for this, simply on the basis that unless there is a continuing involvement, it may be impossible to tell when action might be necessary or some initiative might be needed. An alternative and possibly more practicable solution might be to maintain the informal approach, but to provide more efficent "rescue" machinery for cases which do go wrong, or in which problems occur. This would probably involve new and enlarged emergency intervention procedures which would allow rapid and comprehensive action to be taken whenever necessary, and might also be combined with improved guidance on practice for the professionals concerned.[24]

Principles and Values

4.17 The philosophies which should underlie legislation for the care and guardianship of mentally incapacitated people have been the subject of much international debate in recent years. Various basic principles have gained widespread recognition[25] as matters to which any modern

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24. See paras. 6.33-6.35 above.

25. See, for example Law Reform Commission of Australia, Report No. 52, Guardianship and Management of Property, (1989), p.6, paras. 2.3-2.7 which lists as basic principles to be followed: presumption of competence, least restrictive intervention, encouragement of self-management, community integration and substituted

legislation should have regard. Whilst opinions may legitimately differ upon these principles and values and their application in any particular circumstances, any law reform will need to reflect and, in some instances, to reach a compromise or conclusion upon them. Given the wide variety of situations and issues which can arise, it is unrealistic to expect that it will be possible to apply the same solutions over the whole range of problems. However, the choice between different solutions may be informed by these principles. In the following paragraphs we summarise the position which debate on the main issues now appears to have reached and would welcome views upon the matters raised.

(a) Normalisation

4.18 This principle can be expressed in a variety of different ways. Fundamentally, it aims to treat mentally disordered people as much like other people as possible and to integrate them into the mainstream of everyday life. It also encompasses the maximisation of potential by encouraging people who are to some extent mentally disordered or incapacitated to make decisions for

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25. Continued judgment. Scottish Action on Dementia, Dementia and the Law: The Challenge Ahead, (1988), p. 17 lists the following principles: a right to comprehensive care and protection, minimum necessary compulsory intervention, a simple "one door" procedure and direct community involvement. New Zealand Institute of Mental Retardation Guardianship for Mentally Retarded Adults: Submissions to the Minister of Justice, (1982), pp.5-7 lists: protection of those who cannot protect themselves, minimisation of stigma, presumption of competence, recognition of varying capacities of individuals, normalisation and integration, least restrictive alternative, maximisation of self-determination and self reliance, maximisation of capabilities and due process in restriction of rights.

themselves, so that they can learn from them and thus attain a greater degree of independence. For example, a person who does not live at home is not necessarily or even probably unable to decide how to spend his pocket money or what time to go to bed. Another aspect of this is the recognition that, taken to its logical conclusion, the maximisation of potential can involve allowing a person to take calculated risks, and to suffer the consequences when things go wrong.[26]

(b) The presumption of competence

4.19 This principle requires all dealings with mentally disordered people and all legislation to be based on the premise that every individual is capable of looking after his own affairs until the contrary is proved. It follows that although people may have to be categorised for certain purposes, their general type of disability (mental handicap, senility etc.)should not be used as a criterion; otherwise, once the existence of that disability is proved, a finding of incapacity tends to follow almost automatically.[27] This leads, in effect, to a presumption of incompetence rather than a presumption of competence. Emphasis on functional tests of capacity, rather than "labels", can help to avoid this.[28] The standard of proof of incapacity would normally

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26. D. Carson, "Risk-taking Policies", [1988] J.S.W.L. 328. A conference on Risk-taking in Mental Disorder took place at Southampton University on 23 March 1990.

27. See paras. 2.43, 2.44 above.

28. D. Carson, "Overview: Protection vs. Restriction of the Vulnerable", in E. Alves (ed.) Issues in Criminological and Legal Psychology No. 10: Mental Handicap and the Law, (1987), p.42,45 argues that the decision whether to impose anything should depend on the problem to be tackled rather than categorisations or classifications, and that this approach, by "mainstreaming" mentally incapacitated people minimises the need to resort to stigmatising special laws.

be the balance of probabilities; however, it could be argued that, in view of the drastic consequences of an adverse finding, the criminal standard of proof beyond reasonable doubt would be more appropriate. The presumption of competence needs to operate alongside a clear system for determining incapacity, and, when relevant, degrees of incapacity, and its consequences.

(c) The least restrictive alternative

4.20 This principle has two distinct aspects. The first is that treatment or care should be provided in the least restrictive circumstances possible, for example, in an open rather than a locked ward, or in the community rather than in an institution. The second is that "preference must be given to the means of accomplishing an end that least restricts individual rights",[29] so that intervention must be the minimum required to provide adequate protection. This has led, not only to a preference for informality rather than compulsory powers, but also to the development of the concept of limited guardianship, which is tailored to meet the particular needs of the individual concerned. In most countries which have the alternatives of limited or plenary guardianship, the former is generally preferred whenever possible.[30]

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29. New Zealand Institute of Mental Retardation, op. cit.

30. e.g. In Victoria, Australia where the Guardianship and Administration Board Act 1986 provides for both limited and plenary guardianship orders, experience has shown that plenary orders are very rare, accounting for less than 1% of orders made. Guardianship and Administration Board, Annual Report 1987-88, Vic. Gov. Pr., 35, 10.

(d) Providing safeguards without stigma

4.21 Stigma arises when others perceive someone to belong to a particular category (i.e. the incompetent) about which they have negative preconceptions. This can be minimised by well designed procedures framed in a way which, so far as possible, recognises the widespread reluctance of families and professionals to invoke formal provisions. For example, archaic and stigmatising terminology should be abandoned and, when hearings are necessary, they should be conducted in an informal way in an unintimidating atmosphere. This principle also argues for a non-categorising approach.[31]

(e) The "substituted judgment" versus the "best interests" test

4.22 Two different tests have been developed for making decisions on behalf of a mentally incapacitated adult. The "best interests" standard is derived principally from child care law and represents the more paternalistic and at times restrictive approach: the decision taken is that which the decision-maker thinks is best for the person concerned. It was adopted in Re F.[32] Under the "substituted judgment" standard, decisions made for an incapacitated person attempt to arrive at the choice that particular person would have made had he been competent to do so.[33] This has, for

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31. Carson, op. cit.

32. [1990] 2 A.C. 1. The version of the test used in that case may also be criticised. See paras. 2.22-2.24 above.

33. An interesting comparison may be made in the context of the substituted judgment standard with the concept of "benefit" as developed in the jurisdiction under the Variation of Trusts Act 1958. In trust law, a power of

example, been adopted as the correct standard for the execution of a statutory will. In Re D.(J.), Megarry V.-C. said "it is the actual patient who has to be considered and not a hypothetical patient. One is not concerned with the patient on the Clapham omnibus... I do not think that the Court should give effect to antipathies or affections of the patient which are beyond reason. But subject to all due allowances, I think the Court must seek to make the will which the actual patient, acting reasonably, would have made if notionally restored to full mental capacity, memory and foresight."[34] More recently, the "best interests" and "substituted judgment" tests have been combined in deciding whether it would be best for a severely handicapped baby to be allowed to die rather than to be given strenuous life-saving treatment. In Re J (a minor)(wardship: medical treatment),[35] the Court of Appeal adopted the following passage from the judgment of McKenzie J. in Re Superintendent of Family and Child Service and Dawson:[36] "It is not appropriate for an external decision-maker to apply his standards of what constitutes a livable life

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33. Continued
advancement, exercisable for the benefit of a beneficiary, has been construed on what might be described as a substituted judgment basis in that "benefit" is looked at from the viewpoint of the beneficiary and is not limited to receiving a financial benefit. Thus, the discharge of a moral or social obligation on the part of a beneficiary has been held to be for the benefit of the beneficiary. See, for example, Re Clore's Settlement Trusts [1966] 1 W.L.R. 955. For a similar approach to "benefit" in section 1 of the Variation of Trusts Act 1958 see Re C.L. [1969] 1 Ch. 587. See also Re Remnant's Settlement Trusts [1970] Ch. 560, 566, where the "benefit" of maintaining family harmony was held to outweigh a financial detriment.

34. [1982] Ch. 237, 243-4.

35. [1990] 2 W.L.R. 140.

36. (1983) 145 D.L.R. (3d) 610.

...The decision can only be made in the context of the disabled person viewing the worthwhileness or otherwise of his life in its own context as a disabled person - and in that context he would not compare his life with that of a person enjoying normal advantages. He would know nothing of a normal person's life having never experienced it."

4.23 The substituted judgment standard is generally thought preferable to the best interests test in principle.[37] Attractive though it may be in theory, however, applying it in practice raises problems. It is more difficult to apply in the case of someone who has never had capacity, for example, someone suffering from severe mental handicap. Most significant decisions in such a person's life will invariably have been taken by others and any choices made by him will have been from a very restricted range of options. Consequently, it can be difficult to draw meaningful conclusions about the views or values he would have had if of full capacity. Any decision will inevitably be influenced by the decision-maker's view of what will be best for him, and the distinction between the two tests may be little more than a matter of language. The substituted judgment standard is easier to apply in the case of someone who once had capacity. There is a chosen life-style to refer to and he is likely to have expressed views on a variety of subjects in the past. But even then there are difficulties. What is to be done if the person in question was throughout his earlier life a

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37. e.g. The Law Society's Mental Health Sub-Commitee, Decision-making and Mental Incapacity: A Discussion Document, (1989), p.6; Law Reform Commission of Australia, Report No. 52, Guardianship and Management of Property, (1989), p.6; R. Creyke, "Guardianship: Protection and Autonomy" in J. Eekelaar and D. Pearl (eds.), An Ageing World: Dilemmas and Challenges for Law and Social Policy, (1989), p.560.

notoriously bad judge of certain matters? Although the interpretation put upon the substituted judgment test by Megarry V.-C. above allows for modification of the more fanciful possibilities in such circumstances, the introduction of an element of reasonableness detracts from the very purpose behind adopting this standard. Given that some degree of "censorship" by those applying the test is probably inevitable, it is difficult to know whether it would in the vast majority of cases make much practical difference. The distinction is, perhaps, likely to be more important as an indication of ethos and emphasis: thinking oneself into the shoes of the person concerned and recognising the value we all place on personal preferences (not all decisions are, or should be, taken on reasonable grounds) is a mark of respect for human individuality which may have a value greater than its practical effect.

(f) Achieving a balance

4.24 The demarcation between these principles is not always particularly clear, some overlap[38] and others are to some extent pulling in different directions, reflecting the conflict found throughout this subject between self determination and paternalism, rights and welfare, autonomy and protection.[39] However one expresses it, the dilemma remains the same and one of the more difficult and important decisions to be made will be judging the correct point in any new legislation at which to halt the pendulum. There can be little doubt that there are occasions when

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38. New Zealand Institute of Mental Retardation, op. cit., at p.9 "the principle of normalisation and the principle of the least restrictive alternative could be considered to be just two sides of the same coin".

39. See para. 1.12 above.

intervention is justified; the debate concerns the circumstances in which it should take place. Different degrees of intervention will be appropriate in different circumstances, and there are bound to be differing opinions upon the right degree in any particular case. If the intention is to maximise an individual's own decision-making capacity, then the legal system can respond by requiring a comparatively low threshold when determining competence. Nevertheless, whilst lowering this threshold may be good for the welfare of the individual in terms of autonomy and learning to take responsibility for his own actions, it may be positively bad in other respects, such as, financial decision-making or the care of and provision for his dependants.

4.25 However, it would be consistent both with the traditional approach of English law and with the normalisation principles that the threshold of capacity should remain relatively low.[40] It is not easy to see how any legal system which allows one person to take decisions on behalf of another can at the same time preserve that person's ability to make the decision for himself if he can. A distinction should therefore be drawn between mechanisms which are designed to help a vulnerable but capable person to lead as normal a life as possible and those which are designed to ensure that proper decisions are taken on behalf of those who cannot do so for themselves.

4.27 The aims of policy in this area may perhaps be summarised thus:

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40. See para. 2.44 above.

(i) that people are enabled and encouraged to take for themselves those decisions which they are able to take;

(ii) that where it is necessary in their own interests or for the protection of others that someone else should take decisions on their behalf, the intervention should be as limited as possible and concerned to achieve what the person himself would have wanted; and

(iii) that proper safeguards be provided against exploitation, neglect, and physical, sexual or psychological abuse.

PART V

THE EXPERIENCE ABROAD

The Move towards Reform

5.1 The last two decades have seen an increasing trend throughout Western Europe, Canada, Australia and New Zealand for substantial reform of the law relating to mentally incapacitated adults, earlier versions of which have, for many of the reasons previously discussed,[1] come to be regarded as out of date and unduly restrictive. In some cases, particularly in common law jurisdictions, this has resulted in the establishment of a completely new statutory guardianship scheme; in others, reform has been on a more ad hoc basis. In consequence, there has been a great deal of debate about the principles to be adopted, and the best way to achieve desired aims and objectives. Also, a variety of models are available for examination and comparison.

Canada

(a) The common law provinces

5.2 All Canadian common law provinces except Newfoundland have statute based guardianship laws enabling applications to be made to a court for the appointment of a guardian for an adult thought to be mentally incapacitated. Canadian law begins with a presumption of competence, and distinguishes broadly between incapacity in relation to personal care decisions and property matters. Guardianship

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1. See paras. 2.1-2.8 above.

is seen as a response to a long term need for assistance in decision-making, and separate legislation generally provides for emergency intervention. The detail of guardianship legislation varies considerably between the different provinces, but there are two main approaches, the "traditional" system which regards incompetence as absolute and on proof of incapacity imposes a blanket disability that prevents the exercise of any civil rights, and the system adopted in Alberta, which is the result of one of the earlier attempts completely to rethink guardianship laws.[2]

(b) Ontario - A traditional example

5.3 The legislation in Ontario can be used as an illustration of the traditional Canadian model.[3] Under the Mental Incompetency Act 1980, it is possible to apply to the court for a declaration that a person is mentally incompetent.[4] If, on the evidence of two medical practitioners, including one specialist, and one lay person

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2. There have, however, been proposals for reform in some other provinces, e.g. Law Reform Commission of Saskatchewan, Proposals for a Guardianship Act Part I: Personal Guardianship, (1983).

3. M.E. Hughes, "Personal Guardianship and the Elderly in the Canadian Common Law Provinces: An Overview of the Law and Charter Implications", in J. Eekelaar and D. Pearl (eds.), An Ageing World: Dilemmas and Challenges for Law and Social Policy, (1989), pp.619-622; P. McLaughlin, Guardianship of the Person, (1979), pp.41-46.

4. Mental Incompetency Act 1980, s.1(e) provides that a mentally incompetent person is someone "(i) in whom there is such a condition of arrested or incomplete development of mind, whether arising from inherent causes or induced by disease or injury, or (ii) who is suffering from such a disorder of the mind, that he requires care, supervision and control for his protection and the protection of his property...".

who knows the individual in question, the court is satisfied beyond a reasonable doubt, it may make a declaration of incompetence.[5] Otherwise, it may direct a trial of the issue.[6] Once the declaration has been made, the court may appoint a guardian (known as a "committee") of the person, or of the estate, or both. There is an alternative procedure for use when a person is incapable of managing his affairs through mental infirmity due to disease, age or other cause, or by reason of habitual drunkenness or the use of drugs. However, it seems that in this case the court can appoint only a guardian of the estate and not a personal guardian.[7] There is no provision in the Mental Incompetency Act for notice to be given to the person concerned,[8] or for limited or partial guardianship orders. There are no time limits on orders and no automatic review or supervision of the guardian. The Act does not set out the powers and duties of a guardian, or make it clear whether the person subject to the guardianship may retain any, and if so which, rights.[9] As a consequence guardianship laws in Ontario and other Canadian provinces have been strongly criticised as being "cumbersome, expensive and highly stigmatic".[10] Proposals for extensive

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5. Ibid., s.7(1).

6. Ibid., s.8(1).

7. Ibid., s.39(3). See also Hughes, op. cit., p. 621.

8. Although he would in practice receive notice as normal rules of civil procedure apply. See Hughes, op. cit., p.620.

9. Nor has the situation been greatly improved by case law. McLaughlin, op. cit., p.44 says "... case law relating to guardianship of the person in Ontario can best be described as non-existent.".

10. e.g. Law Reform Commission of Saskatchewan, Tentative Proposals for a Guardianship Act, (1981), pp.8-10 points out as the main deficiencies "(i) while there is authority to appoint a personal guardian for a mentally disordered person, there is no authority in respect of a

reforms have been presented by an advisory committee which was established in 1985, but no steps have, as yet, been taken to implement its recommendations.[11]

(c) Alberta - The Dependent Adults Act 1976

5.4 The Dependent Adults Act 1976 is based on the principle that intervention in the life of an individual should be the minimum necessary to provide him with the protection and assistance he requires. It provides a comparatively straightforward procedure whereby any interested person can bring an application for a guardianship order. The legislation provides for partial guardianship orders to be made covering specific matters, leaving the dependent adult with control, and retaining full rights in all other areas of his life. There was originally power to make plenary guardianship orders when a limited order was insufficient, given the needs of the person concerned, but these were abolished in 1985[12], and plenary power can only now be built up by the court enumerating all the possible powers in one order. The Act provides that before an order is made the court must be satisfied that the person concerned is repeatedly or continuously (i) unable to care for himself and (ii) unable to make reasonable judgments in respect of matters relating to his person.[13] The court must also be satisfied that such an order is

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10. Continued
person neither declared or adjudged mentally disordered; and (ii) the notion that a person must be "mentally disordered" before a personal guardian may be appointed has outlived its usefulness as an indication for whom the law ought to appoint personal guardians." See also McLaughlin, op. cit., and Hughes, op. cit.

11. Final Report of the Advisory Committee on Substitute Decision Making for Mentally Incapable Persons, (1987).

12. Dependent Adults Amendment Act 1985, ss.2, 11(1).

in his best interests and will result in a substantial benefit to him.[14] As a test of incapacity, these criteria have been criticised on several counts. Particularly, their failure clearly to identify the need for the judge to satisfy himself that there is no alternative to guardianship, and the general vagueness of the standards required which give considerable scope for subjective value judgments about how people ought to live their lives.[15] The Act contains a number of procedural safeguards, such as notice and service upon the person concerned,[16] and provision for him to appear and make representations.[17] It also provides for automatic review of all guardianship orders, and gives the court power to specify time limits.[18]

(d) Emergency protection legislation in Canada

5.5 Three Canadian provinces have special emergency protection legislation designed to respond more quickly than guardianship to crises arising when adults who are unable to look after themselves are at risk due to abuse or neglect.[19]

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13. Dependent Adults Act 1976, s.6(1), as substituted by the Dependent Adults Amendment Act 1985, s.7.

14. Ibid., s.6(2).

15. e.g. McLaughlin, op. cit., pp.94-96 questions whether (i) means unable to care for himself at all, or only unable to care for himself very well, and suggests that the question of self-care overlaps with, and may often be the same as making reasonable judgments. See also Hughes, op. cit., p.623.

16. Dependent Adults Act 1976, s.3(2).

17. Ibid., s.5.

18. Ibid., s.8.

19. The relevant statutes are; in Newfoundland, Neglected Adults Welfare Act 1973; in New Brunswick, Family Services Act 1980 and in Nova Scotia, Adult Protection Act 1985.

The provisions in these statutes differ in detail, but they contain some fairly sweeping powers and duties. For example, in Newfoundland, there is a duty on anyone who has information, whether privileged or not, that an adult is in need of protection, to report it.[20] All the statutes give powers of investigation to social or community officials and enable them to apply to a court for an order declaring that a particular adult is a person in need of protection.[21] Once the court is satisfied of this, it must make one of a variety of orders, depending upon what it considers to be that person's best interests. These include orders for hospitalisation and treatment, or placement in the care and custody of a responsible adult or the Department of Social Services. There are also powers for the court to order the payment of maintenance for an adult in need of protection, and restrict access to such a person by anyone who poses a danger to him.[22] These powers are extensive and fairly radical. They have not escaped adverse comment, one commentator concluding that adult protection legislation in Canada can be criticised "for paternalistic overreach, and for failing to effectively balance state protective intervention and the right of the adult to self-determination and due process."[23]

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20. Neglected Adults Welfare Act 1973, s.4. There is a similar duty in Nova Scotia under the Adult Protection Act 1985, s.2.

21. Hughes, op. cit., pp.625-6.

22. Neglected Adults Welfare Act 1973, s.6(4); Family Services Act 1980, s.39(1); Adult Protection Act 1985, s.9(2).

23. Hughes, op. cit., p. 626.

Australia

(a) Guardianship laws

5.6 The majority of Australian states either have recent guardianship legislation, or are in the process of drawing up new proposals.[24] The principal model is the Guardianship and Administration Board Act 1986, in Victoria. Most other states have been strongly influenced by this legislation, although all the systems differ in certain respects.[25] The legislation revives the concept of personal guardianship which had previously fallen into disuse, and attempts to create laws based explicitly upon principles, such as the least restrictive alternative, normalisation and autonomy, which have evolved in recent years as appropriate standards against which such efforts should be judged.

5.7 Under the Guardianship and Administration Board Act, an Administrative Board with multi-disciplinary composition is responsible for applying the new law. Applications may be made to the Board for an order appointing a personal guardian, or an administrator of the estate, or for a mixed order. When entertaining an

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24. For a review of the different systems, and the background, see T. Carney and P. Singer, Ethical and Legal Issues in Guardianship Options for Intellectually Disadvantaged People, (1986).

25. Other legislation includes; in the Northern Territories, Adult Guardianship Act 1988; in Queensland, Intellectually Handicapped Citizens Act 1985; in New South Wales, Protected Estates Act 1983 and Disability Services and Guardianship Act 1987; in South Australia, Mental Health Act 1977. "Old" legislation remains in force in Western Australia, Mental Health Act 1962 and Supreme Court Act 1935, and in the Australian Capital Territories, Lunacy Act 1898. However, in respect of the latter, new recommendations have recently been made by the Australian Law Reform Commission Report No.52, Guardianship and Management of Property, (1989).

application for a guardianship order, the Board must assess whether the needs of a person may be met by a less restrictive means than guardianship.[26] A plenary guardianship order may be made only when a limited order would be insufficient to meet the needs of the person concerned;[27] when limited orders are made, they should be in the least restrictive form possible.[28] Criteria for the appointment of a guardian[29] are again three-fold, that the person subject to the application is (i) a person with a disability, (ii) unable to make reasonable judgments in respect of all or any matters relating to his personal circumstances, and (iii) in need of a guardian.[30] The powers and duties of guardians and administrators are set out in some detail,[31] and there is provision for temporary orders to be made in urgent cases.[32] The Board has special emergency powers enabling it to order the Public Advocate or any other specified person accompanied by a police officer to visit a person suffering from a disability, and prepare a report.[33] On receipt of the report, the Board may make an

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26. Guardianship and Administration Board Act 1986, s.22(2).

27. Ibid., s.22(4).

28. Ibid., s.22(5).

29. Ibid., s.22(1).

30. The criteria for the appointment of an administrator of the estate are virtually identical. The only differences are that under s. 46, the Board has to be satisfied that the person is "unable to make reasonable judgments in respect of... his estate" and "is in need of an administrator of his estate".

31. Ibid., ss.24-32, 48-58.

32. Ibid., ss.32, 33, 59, 60.

33. Ibid., s.27. These powers are exercisable when the Board receives information on oath that a person with a disability in respect of whom a guardianship application has been made is (a) being unlawfully detained against his or her will; or (b) is likely to suffer serious

order enabling that person to be taken to a place of safety until a guardianship application is heard.

5.8 The Office of the Public Advocate has been created as a watchdog agency on behalf of incapacitated people. The Public Advocate acts as a guardian or administrator where no other suitable person is available, and has responsibility for educating the public on issues relating to disability.[34] The Act also contains various procedural safeguards, seen as a means of protecting against arbitrary and unnecessary guardianship appointments.[35] These include notice of proceedings,[36] provision for the person concerned to attend and be represented,[37] and provision for reviews and appeals.[38] The Board appears to have been broadly successful in its aim to create an informal and accessible

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33. Continued
damage to his or her physical, emotional or mental health or well-being unless immediate action is taken.

34. Guardianship and Administration Board Act 1986, ss.14-16 and Schedule 3.

35. R. Creyke, "Guardianship: Protection and Autonomy - Has the Right Balance been Achieved?", in Eekelaar and Pearl, (1989), op. cit., p.558.

36. Guardianship and Administration Board Act 1986, s. 20 provides for notice to be given to at least seven people, the applicant, the person in respect of whom the application is made, the nearest relative, the primary carer, the proposed guardian, the Public Advocate, any administrator of the estate and any other person whom the Board directs.

37. Ibid., s. 12.

38. Ibid., ss.61-63, 67.

atmosphere in which those appearing before it report a high degree of satisfaction with the proceedings.[39]

(b) Consent to medical treatment

5.9 In 1988, the case of Re "Jane",[40] was heard in the Family Court in Victoria. It was held that the consent of the court is necessary as a matter of routine in order to perform on a child, or a mentally incapacitated adult, medical procedures which have non-therapeutic objects as their principal aim and which involve interference with a basic human right. Statutory provisions in different states vary. In Victoria, the Guardianship and Administration Board Act 1986 contains provisions intended to protect people subject to the jurisdiction of the Board from being unnecessarily subjected to medical procedures.[41] These prevent a plenary guardian, or a limited guardian with power to consent to health care from consenting to any "major medical procedure" without the consent of the Board. Any doctor who carries out such a procedure without the consent of the guardian and the Board is guilty of professional misconduct. Provision is made for a hearing to take place within 14 days of any application for consent being made. The Board is specifically required to ascertain, so far as possible, the wishes of the person concerned, and to give effect to his wishes if satisfied that he is capable of consenting to the procedure. Otherwise, the Board may consent to the procedure if satisfied that it is in his best interests.

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39. T. Carney, "Client Assessment of the Guardianship and Administration Board", (1989) 15 Monash L. Rev. 229.

40. (1988) 85 A.L.R. 409.

41. ss.36-42.

5.10 The Medical Treatment Act 1988 [42] in Victoria further clarifies the extent of the guardian's powers in relation to consent to medical treatment. It provides that if guardians and agents appointed under an enduring power of attorney are specifically authorised to do so by the court or their principal, they may make decisions about medical treatment, including refusal of treatment.[43]

New Zealand - The Personal and Property Rights Act 1988

5.11 Under the Personal and Property Rights Act 1988, the Family Court has jurisdiction in respect of the personal rights of anyone who (i) lacks wholly or in part the capacity to understand the nature and foresee the consequences of decisions in respect of matters relating to his personal care or welfare or (ii) has such capacity, but wholly lacks the capacity to communicate decisions in respect of such matters.[44] In property matters, the court has a much wider jurisdiction in respect of any persons who lack wholly or in part the competence to manage their own affairs in relation to their property.[45] Thus, there is no test of capacity to understand or ability to communicate. The Act lists a wide variety of personal orders which may be made by the Family Court[46] up to, in the last resort, the

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42. This came into operation on 1 September 1988.

43. Creyke, op. cit., p.561.

44. Personal and Property Rights Act 1988, s.6.

45. Ibid., s.25.

46. Ibid., s.10. These include matters such as remuneration for work, arrangements for personal care after the death of parents, entering or attending a residential institution, living arrangements, medical arrangements, education or rehabilitation and the appointment of a next friend or guardian ad litem.

appointment of a welfare guardian[47]. A welfare guardian may not be appointed unless there is a complete inability to make or communicate decisions and the court is of the opinion that making the order is the only satisfactory way to ensure that appropriate decisions are made on behalf of the disabled person. The powers of welfare guardians are specified in the order appointing them, but there are certain powers which they may not be granted. These include decisions about marriage, divorce, adoption, refusal of consent to standard medical treatment, ECT and medical experimentation.[48] The legislation has not provided a specific answer to whether the provisions of the Act are wide enough to allow the Court to give approval to controversial medical procedures. This has been described as "unfortunate", and it has been doubted whether the Act could be used to approve sterilisation and abortion or the removal of non-regenerative tissue.[49] Separate parts of the Act deal with property rights, and the appointment of and powers of managers to deal with them.[50] There is a special procedure[51] for the administration of property of small value,[52] to avoid the more extensive and strict provisions relating to the appointment of managers.

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47. Ibid., s.12.

48. Ibid., s.18(1).

49. A.C. Hughes-Johnson, "The Protection of Personal and Property Rights Act 1988 - an analysis, commentary and answers to likely questions", New Zealand Law Society Seminar Paper, (1988), p.11.

50. Protection of Personal and Property Rights Act 1988, Parts III, IV and V.

51. Ibid., s.11.

52. Not exceeding $1,000 in value, or $10,000 in income in any one year.

5.12 The Act also provides for the execution of and regulation by the court of enduring powers of attorney.[53] These may authorise an attorney to act generally, or in relation to specific things only, including the donor's personal care and welfare. The attorney may not, however, act in respect of any of the matters in which personal orders may not be made. Enduring powers of attorney are subject to orders of the court in that where any conflict exists, the terms of the personal or property order will prevail.

Scandinavia

5.13. The most interesting model in Scandinavia is the new system in the process of development in Sweden. Norwegian law provides similar solutions to Sweden, whereas in Denmark the system is based on a traditional guardianship institution, but with increased flexibility and procedural guarantees.[54] Swedish law has, since 1949, provided a procedure whereby someone can, on a number of criteria, be declared legally incompetent by court order.[55] These criteria are not limited to mental disorder, but include hazarding the welfare of oneself or one's family by wastefulness, negligence or the abuse of intoxicants. On making an order of incompetence, the court must appoint a guardian to provide for the ward's welfare and to administer his property. The ward is thereby deprived of all civil

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53. Protection of Personal and Property Rights Act 1988, ss.95-107.

54. L. Vogel, Systems for the Representation and Legal Protection of the Mentally Handicapped, Association Internationale Autisme-Europe, (1988), p.7.

55. Code 1949 relating to Parents, Guardians and Children, (in Swedish, Foraldrabalken, FB).

and legal rights. Guardianship is completely under official supervision and control, being administered by the courts and by municipal authorities known as "chief guardians".[56]

5.14 In 1974, significant reforms were introduced greatly limiting the use of guardianship.[57] The concept of a "godman" or "special representative" was created, with the function of providing assistance and advocacy for the disabled person. A special representative is a paid social worker with legal status and the authority to carry out certain acts on behalf of his principal. Like guardians, special representatives are subject to the control of the courts and the chief guardians. As guardianship can now only be used if the appointment of a special representative or help from other sources is insufficient, it has become a comparatively rare procedure.[58] A special representative can be appointed for anyone who, due to illness, mental deficiency, weakened health or the like needs assistance to take care of his rights, administer his property or take care of himself.[59] The principal must consent to the appointment, or be unable to give a valid consent. The authority of the special representative does not preclude that of the principal, who retains all legal capacity and may make transactions in the same field as the former.

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56. P. Westman, "Guardianship and Protection, The Swedish Example", (1988) (paper presented to the VI World Conference of the International Society on Family Law).

57. Code 1949, op. cit., ch.18 sec.3.

58. Between 1976 and 1985, only 10 people were placed under guardianship in Sweden. Vogel, op. cit., p.7.

59. In 1985 there were about 20,000 people in Sweden for whom a special representative had been appointed. Westman, op cit., p.5.

This can result in "colliding" transactions being made and paradoxically, people with milder forms of disability tend to be at greater risk of being declared totally incompetent than those with severe mental incapacity, as the former are more active and more liable to come into conflict with their representative.[60]

5.15 In 1988 new legislation was passed by the Riksdag to abolish the old declaration of incompetence in its entirety, and replace it by power to appoint an administrator, whose authority is defined by the court in relation to specific matters; in effect, a form of limited guardianship.[61] The appointment of an administrator deprives the principal of his legal capacity in those areas in which the administrator is entitled to act, but he retains his capacity in full elsewhere, apart from being disqualified from holding certain public offices. Provision is made for the appointment of a general administrator if a limited appointment would be insufficient. The criteria for the appointment of an administrator are the same as those for the appointment of a special representative with the additional requirement that the proposed principal must not be able to take care of himself or his property.[62]

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60. Westman, op. cit., p.3 draws this conclusion based on an analysis of cases in which the Swedish Supreme Court has dealt with the choice between a declaration of incompetence and the appointment of a special representative.

61. SFS 1988: 1251-1368. This was based on a report of the Guardianship Commission, "God man och forvaltare", SOU 1986:50.

62. Westman, op. cit., Supplement.

Civilian Systems

(a) Traditional interdiction procedures

5.16 There are many similarities between the systems found in most continental countries, particularly those whose laws are based on the Napoleonic code. Traditional laws generally provided a procedure of "interdiction", that is, a declaration of legal incompetence whereby the person concerned lost all civil and legal rights, and had a plenary guardian appointed whose main functions related to the management and administration of property, although he might also have some ancillary personal welfare responsibilities.[63] A typical example can be found in Austrian law, which, prior to reforms introduced in 1983, provided for a declaration of incompetence which, depending on the category of mental disability into which the person fell, resulted in his reduction to the status of an infant below the age of seven years, or in losing totally, or for the greater part, competence to enter into legal transactions.[64] This operated in conjunction with an extended minority to the age of 21. Control, once imposed, was generally lifelong.[65]

5.17 Such systems have been the subject of much criticism.[66] Besides the obviously stigmatising and draconian consequences of such laws, they resulted in the

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63. B. Schulte, "Reform of Guardianship Laws in Europe - A Comparative and Interdisciplinary Approach", in Eekelaar and Pearl, (1989), op. cit., p.591.

64. Civil Code of 1 June 1811, as amended by Ordinance of 28 June 1916 and Law of 20 November 1958.

65. Schulte, op. cit., p.597.

66. Ibid., pp. 592-595.

frequent unnecessary imposition of general limitations on capacity. Procedures were unduly expensive and protracted. The incapacitated person was generally unrepresented. Many guardians were not sufficiently competent and judicial control of their activities was either inadequate or non-existent. As guardians were chosen for the principal purpose of administering property, they were often lawyers or accountants, and were not fully aware of the needs of their wards or skilled in dealing with disabled people.

5.18 Changes in attitudes to mental incapacity and many of the other factors previously discussed[67] provided a strong impetus for the reform of guardianship laws. In consequence, they have changed profoundly in most western European countries during the last 20 years, and in some cases, for example, Austria and West Germany, complete reform has taken place, or is projected.

(b) Austria

5.19 In Austria, the reforms introduced in 1983[68] provided less restricted forms of guardianship, including degrees of limited guardianship, and reinforced the position of the ward in relation to the guardian, allowing him to retain full capacity in all areas of his life not subject to the guardianship order.[69] The guardian's powers were further clarified and restricted by the introduction of new legal controls, such as compulsory periodic reviews and

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67. See paras. 2.1-2.8 above.

68. Bundesgesetz vom. 2 Feber 1983 uber die Sachwalterschaft fur behinderte Personen, Bundesgesetzblatt, 1983, 55 Stuck, 4. Marz 1983.

69. Ibid., Article 273, section 3.

annual accounts.[70] Although the court cannot stand in the guardian's shoes as a decision-maker, there is provision for it to give directions or guidelines in relation to specified matters, and if there is a conflict, an ad hoc trustee[71] can be appointed to replace the guardian in the disputed area. Ultimately, the guardian can be replaced by someone else. There are procedural guarantees governing standing to make an application, providing for an oral hearing, and for the attendance and representation of the allegedly incapacitated person. If he cannot attend, the Judge is required to visit him.[72] Unusually, the guardian's permission to marry is still necessary, even where marriage is not specified as being within the guardian's terms of reference. The court will make the final decision in the event of a dispute between the guardian and the ward.[73] A person subject to guardianship may still make a will, but can only do so orally before the court or a notary.[74] All the old law was repealed with the exception of the concept of extended minority which can still continue until 21.[75] A new independently organised and state subsidised institution, the Sachwalterverein, has been set up, staffed by legally trained professional social workers, with the intention of

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70. Ibid., Article 283.

71. Known as a "Kollisionskurator".

72. Ibid., Article 237.

73. Vogel, op. cit., p.10.

74. Ibid.

75. Para. 173, section 1 of the Civil Code now provides that "the court shall, ex officio or at the request of the father or mother, extend the child's minority before he becomes of legal age, if the child, particularly as a result of significantly retarded development, cannot conduct his affairs without the risk of a disadvantage to himself". This extended minority cannot last beyond the age of 21. Vogel, op. cit., p.8.

providing competent advocacy and support where there is no suitable relative or friend available.[76]

(c) Germany

5.20 Aspects of the Austrian reforms inspired reform proposals in the Federal Republic of Germany, although many of the specific provisions are different in detail. Proposals were put forward in 1988[77] completely to replace the present system, which provides two alternative procedures. First, it is possible to obtain a declaration of incompetence that, if based on mental illness, imposes blanket incapacity regardless of the individual abilities of the person concerned. If based on feeble mindedness, squandering, drug or alcohol addiction, it reduces the person concerned to the status of a child of the age of seven.[78] The incompetency procedure is governed by strict procedural rules and has a severe and stigmatizing effect. An alternative "tutelage" procedure is available for people who are unable to take care of certain aspects of their affairs owing to mental or physical frailty.[79] The latter has become more widely used, but under either system the Civil Code ceases to recognise that person as having any

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76. Schulte, op. cit., at p.598 suggests that the expansion of state-subsidised guardianship has been rather slow due to lack of time and resources and the persistence of traditional attitudes, but concludes that experiences with the new legislation have been positive as regards the legal position of those subject to it.

77. Known as "Bétreuungsgesetz".

78. Section 104, German Civil Code.

79. Section 109, German Civil Code.

rights, but only interests which the guardian is henceforth responsible for protecting, largely at his own discretion.[80]

5.21 The new proposals were passed by the Bundestag on 12 September 1990 and will come into force throughout Germany on 1 January 1992.[81] Guardianship and tutelage will be replaced by "care and assistance", or "Betreuung", which has been designed as a uniform system permitting a flexible combination of support and intervention, depending upon the requirements of each individual.[82] A care-taker, or "Betreuer" may be appointed by the court at the request of the person concerned, or where he is unable, owing to mental or physical incapacity, to manage his own affairs. The legislation is framed to promote the welfare and autonomy of those subject to it, and their wishes and desires are given priority whenever possible. There is, for example, an obligation on the Betreuer to assist the person concerned to make use of any health care or rehabilitative measures, which might enable him to manage without a Betreuer. Substantive and procedural rules are provided on matters such as health care, housing and the management of property. The ability to marry or make a will is not affected.

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80. G. Zenz, "The End of Guardianship for the Elderly? Facts and Objectives in Current Discussions on the Proposed Reform Legislation in the Federal Republic of Germany", in Eekelaar and Pearl, (1989), op. cit., p.609.

81. Although the new law was enacted before the accession of the former German Democratic Republic to the Federal Republic, it will extend to East Germany by virtue of the general principle laid down by article 8 of the Treaty of Union which, subject to various exceptions and qualifications, applies the West German legal system to East Germany.

82. Zenz, op. cit., p.614.

5.22 There are special provisions governing certain decisions which have particularly far-reaching consequences. Of special interest are the provisions banning the nonconsensual sterilisation of minors and regulating that of adults.[83] The legislation provides that the Betreuer of an adult may consent to his sterilisation, provided certain conditions are present, and certain procedural guarantees are observed.[84] The consent of the Betreuer must also be confirmed by the guardianship court and the operation may not be performed less than two weeks thereafter. In addition, a series of amendments have laid down the precise nature of the consent process, and the subsequent giving of approval by the court, defining even more closely the circumstances under which sterilisation may be considered. This detailed regulation contrasts significantly with the rather loose "best interests" standard employed by the courts in this country.[85]

Common Trends

5.23 A number of common threads run through this new legislation, and many of the principles and values underlying it are the same. It tends to be focused on the rights, interests and welfare of the person concerned, and

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83. J. Shaw, "Sterilisation of Mentally Handicapped People: Judges Rule OK?", (1990) 53 M.L.R. 91.

84. Ibid. p.95-6. These include the following. The sterilisation cannot be performed if the person concerned expresses opposition to it. The incapacity to consent must be permanent. There must be a concrete risk of pregnancy, which must present a danger to the life of the pregnant woman, or of serious damage to her physical or psychic health which could not reasonably be averted in any other way. Finally, pregnancy must not reasonably be preventable by other means.

85. See paras. 2.22-2.24 above.

is aimed at enabling mentally incapacitated people to gain greater freedom and independence. Once appointed, guardians generally have two main responsibilities, exercising rights on behalf of the mentally incapacitated person or assisting him to exercise his own rights if this is possible, and protecting his interests. The legislation in different countries strives to find ways of balancing these reflections of the conflict between autonomy and paternalism.

5.24 Guardianship orders are made only if the needs of the person concerned cannot be met by other means. This is spelled out particularly clearly in the Guardianship and Administration Board Act 1986, in Victoria, Australia, and decisions of the Board implementing this policy have been upheld on appeal.[86] Other jurisdictions do not seem to go quite as far. New Zealand [87] refers to the least restrictive alternative principle but qualifies it by reference also to "the degree of that person's incapacity" and remaining "consistent with the proper protection and care of that person". This may provide greater scope for orders to be made in cases of doubt.[88] The distinction between the two approaches raises an important issue. How should "need" for guardianship be defined, and should

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86. Orders were refused in cases where the issue was not incapacity but "need" for a personal guardian when all daily needs were being fully met by caring adult children, M. & R. v. The Guardianship and Administration Board [1988] 2 V.A.R. 213; applied in E. v. The Guardianship and Administration Board and the Public Advocate [1988] 2 V.A.R. 222.

87. Personal and Property Rights Act 1988, s. 8.

88. T. Carney, "The Limits and Social Legacy of Guardianship in Australia", (1989) 18 Fed. L.R. 231, 242.

decisions ever be taken on behalf of mentally incapacitated adults without the condition of need being satisfied?

5.25 In keeping with the principle of the least restrictive alternative, most common law jurisdictions have espoused the concept of limited guardianship, which allows the extent of the guardian's authority to be tailored to the particular needs of the person concerned. Plenary orders are permitted only when they are strictly necessary and are rare.[89] The success of limited guardianship orders in practical terms is not easy to assess. The main difficulty is knowing where to set the limits, in view of the formidable problems of assessing capacity and its tendency to fluctuate in certain psychiatric conditions. Civilian systems are more likely to accommodate the least restrictive alternative principle by introducing a graded system with differentiated levels of guardianship.[90] Whilst this approach is less flexible and places less emphasis on individual requirements, it may be more practical to operate. It has, on the other hand, been argued that the use of limited or graded guardianship results in their extension to a wider range of people than the old law of

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89. See para. 4.20 above.

90. Schulte, op. cit., pp.591-603. France has a four tier system of "sauveguarde de justice", "tutelle", "curatelle" and "tutelle aux prestations sociale" which all provide varying degrees of protection and autonomy. The Netherlands has a three tier system, the traditional interdiction procedure, the "curatele" having been supplemented in 1982 by "beschermingsbewind", a form of limited guardianship, and subsequently also by "mentorschap" a special form of personal guardianship for adults. See also the proposed system in Sweden at para 5.15 above.

total incompetence, and that this runs counter to the least restrictive alternative.[91]

5.26 There is a growing trend towards legal and procedural safeguards against abuse or the undue restriction of rights. Safeguards adopted in different jurisdictions differ, but include combinations of the following:[92]

(i) widely drawn standing to make an application;

(ii) improvement in the quality of hearings, some of which are held in public;

(iii) provision for notice to be given to anyone likely to have a useful point of view to contribute;

(iv) a presumption that the person concerned will attend, often backed up by provision for him to be interviewed if he does not;

(v) representation for the person whose capacity is subject to challenge;

(vi) provision for more rigorous testing of medical evidence and for assessments of social competence;

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91. G.H. Morris, "The Use of Guardianships to Achieve - or Avoid - the Least Restrictive Alternative", (1980) 3 Int.J.L. and Psych. 97, 107.

92. Schulte, op. cit., pp.600-603. For a comparison of various procedural safeguards adopted in different Australian States, see Carney, op. cit., at pp. 244-6.

(vii) power to obtain specialist reports;

(viii) prescribed time limits;

(ix) regular reviews;

(x) an appeal procedure;

(xi) provision for reasoned decisions to be given.

5.27 There is a conflict between the need for "due process", represented by procedural safeguards and standards of proof, and welfare considerations which suggest that proceedings should be easily accessible, inquisitorial and conducted in an informal atmosphere. All jurisdictions have to balance these considerations. Greater emphasis on the former may suggest that a court is the proper forum to hear guardianship applications, as being inherently more rigorous in conforming to procedural regularity.[93] On the other hand, multi-disciplinary tribunals are regarded as being stronger on informality and better able to develop the necessary expertise in a specialist area.[94] These may be better able to assess the judgments made by the professionals in health care and social work, and may also be more comfortable in using them than they would be the more formal procedures of a court.

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93. As in Alberta, Canada, New Zealand, the Northern Territories of Australia and most European countries.

94. For example, the Guardianship and Administration Board in Victoria and the Guardianship Board in New South Wales, Australia. A specialist tribunal is also proposed in draft legislation for the Australian Capital Territories. For a further discussion of the respective merits of courts or tribunals as a forum see The Law Reform Commission of Australia Report No. 52, Guardianship and Management of Property, (1989), p.39.

5.28 There is a move away from tests of incapacity which are based on an individual's physical or mental status, or a diagnosis, without further enquiry about how this actually affects his capacity to function. This "non-categorising" or "non-labelling" approach may not restrict the legislation to any specific disabling conditions. Hence, the legislation tends not to be confined to people suffering from mental disorder, but may include the physically disabled and people such as alcoholics and drug addicts. Both the Dependent Adults Act 1976, in Alberta, Canada,[95] and The Guardianship and Administration Board Act 1986, in Victoria, Australia,[96] provide a three-fold test covering disability, functional incapacity, and need for a guardian. The test in New Zealand is framed slightly differently,[97] but shares the same approach.

5.29 There is a growing recognition of the complexity of the role of a guardian, and the need to provide training and education for those who undertake it. Legal systems are also increasingly providing a watchdog or advocacy service, which can also act as guardian of last resort when necessary.[98] All other things being equal, priority is generally given to relatives or friends of the person concerned; but many people, because of the lack of any suitable relatives or family disputes, will have to fall back on professional help.[99]

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95. See para. 5.4 above.

96. See para. 5.7 above.

97. See para. 5.11 above.

98. e.g., the Sachwalterverein in Austria, the Public Advocate in Victoria, and the Public Guardian and Protective Commissioner in New South Wales.

99. In Victoria, the Public Advocate was appointed guardian in 50.9% of personal guardianships, despite the fact that relatives are selected whenever possible. Guardianship and Administration Board, Annual Report 1987-88, Vic. Gov. Pr. 35, p.13.

PART VI

SOME OPTIONS FOR CHANGE

6.1 Possible approaches to law reform in this area have already been mentioned.[1] The main choice is between an overall approach, which aims to supply a single basic mechanism adaptable enough to provide a solution to the problems of mentally incapacitated adults in all areas of life, and a more ad hoc approach, which builds upon the existing legal framework and could be implemented on an incremental basis. The former would probably involve the formation, from scratch, of a new statutory institution, perhaps with a new title. The latter would involve some or all of the many individual proposals which have been put forward. Some of these are complementary and could be successfully combined. The main options available are summarised below.

Advance Directives

(a) The concept

6.2 The purpose of an advance directive is to enable a competent person to give instructions about what he wishes to be done, or who he wishes to make decisions for him, if he should subsequently lose the capacity to decide for himself. Advance directives are usually discussed in the context of medical treatment and relate mainly to the patient's right to refuse or change treatment in a disabling chronic or terminal illness. For many people, this is the least intrusive form of substitute decision-making. It can

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1. See paras. 4.10-4.13 above.

give the person concerned the assurance that his expressed wishes will be followed and his autonomy respected to the highest possible degree. If he appoints his own representative he has the confidence of knowing that the person he has selected will be making decisions for him, rather than someone he might not have chosen. Advance directives can also have the advantage of providing more certainty. If others know that wishes have been expressed or a representative has already been selected, they know what to do when certain decisions become necessary.

6.3 However, advance directives have their limitations.[2] Some people will never have sufficient capacity to use them. Many of those who do will retreat from the idea until too late.[3] Few people face up readily to the prospect of advancing mental deterioration. The use of advance delegation mechanisms requires forethought and the obtaining of proper advice. Decisions also need to be taken about when advance directives should come into effect. If incapacity is taken as the "triggering" event, the intractable problem of establishing the exact time of onset will continue to cause problems.[4] No matter how carefully advance planning is undertaken, contingencies will inevitably occur which could not be foreseen, and for which no arrangements have been made. Advance directives will never, therefore, provide more than a partial solution to the problems facing mentally incapacitated adults, but they have the potential to be a useful addition to the armoury.

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2. See also para. 3.12-3.14 above.

3. As they do from making a will; see our Report on Distribution on Intestacy, (1989) Law Com. No 187, pp.25-26.

4. See para. 2.35 above.

6.4 Advance directives have been developed principally in the United States of America. Legislation varies between different States, and there are a number of models available. The legal standing of advance directives which go beyond the powers contained in the Enduring Powers of Attorney Act 1985 is at present uncertain in this country. There is no reported decision upon the issue, and no specific legislation. The view has been expressed[5] that the English courts would be likely to follow the position adopted by the New Jersey courts in the case of In re Conroy,[6] where it was held that, if known, the incompetent patient's earlier wishes would be determinative. Alternatively, it is possible that an English court would regard wishes expressed by a patient prior to the onset of incapacity as being merely directory and not imposing any obligation. Interest in advance directives in this country appears to be increasing,[7] and some clarification of their legal status seems likely to be desirable. The main models are the following.

(b) Living Wills

6.5 The term "living will" has been called a misnomer, "since it does not control the disposition of property, and deals with dying rather than living".[8] A living will is

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5. Age Concern Institute of Gerontology and the Centre of Medical Law and Ethics, The Living Will: Consent to treatment at the end of life, (1988), p.37.

6. (1985) 486 A 2d 1209.

7. Age Concern and the Centre of Medical Law and Ethics, op. cit.; I. Kennedy and A. Grubb, Medical Law: Text and Materials, (1990), pp. 1117-1155.

8. M.B. Kapp, Preventing Malpractice in Long Term Care: Strategies for Risk Management, (1987), p.152.

essentially a formal declaration by a competent adult expressing the wish that if he becomes so mentally or physically ill that there is no prospect of recovery, any procedures designed to prolong life should be withheld. The object is to rebut any presumption that the patient has consented to treatment which may be administered under the doctrine of necessity, and to give the patient power to direct in advance the treatment, or lack of treatment, that he wishes to receive at the end of his life should he lose the ability to do so at the time.[9] Because of the uncertainty about the legal status of living wills, many States in the U.S.A. have enacted what has become known as "natural death" legislation,[10] which prescribes conditions for the execution of living wills, endorses their validity, and frees medical practitioners and institutions from civil and criminal liability for complying with their terms.

6.6 A number of problems have emerged with the implementation of living wills.[11] Various questions may remain unresolved in the legislation. For example, does a doctor's failure to comply with the terms of a living will constitute professional misconduct? Can the refusal of life sustaining treatment constitute suicide, and what are

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9. For a brief account of the evolution of living wills in USA and Britain, see D.A. Lush, "Living Wills", (1989) 12 L.S. Gaz. 21.

10. The first natural death legislation, the Natural Death Act 1976, was passed in California. By 1987, 38 other states and the district of Columbia had followed suit; Kennedy and Grubb, op. cit., p.1117.

11. President's Commission for the Study of Ethical Problems in Medicine and Bio-medical and Behavioural Research, Deciding to Forego Life Sustaining Treatment: Ethical Medical and Legal Issues in Treatment Decisions, (1983), pp.140-145.

the insurance implications of this?[12] There are fears about undue pressure to sign a living will being placed upon people diagnosed as having a terminal illness, particularly in a country where medical care is largely privately funded. These have led in some States to strict limitations upon the class of people who can make a living will, and to such rigorous procedural requirements that only a small percentage of incapacitated people for whom decisions about life sustaining treatment need to be made are actually eligible to execute them. This obviously curtails the usefulness of the legislation.

6.7 There are many versions of living wills, and the clarity with which they give instructions varies widely.[13] Very detailed living wills risk failing to foresee a particular turn of events, whereas those written in general terms may be ambiguous in their application to particular circumstances and require considerable interpretation by medical practitioners. Either may result in an outcome which the patient might not have wished. Doctors who are unhappy with the terms of a living will can circumvent its operation by refusing to confirm clinically that the triggering condition, normally terminal illness, has actually occurred.[14] The force of paternalism should not be underestimated.[15] It has also been suggested that where

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12. cf. for example the approaches adopted in Beresford v. Royal Insurance [1938] A.C. 586 and Kirkham v. Chief Constable of the Greater Manchester Police [1990] 2 Q.B. 283.

13. Lush, op. cit.

14. Kapp, op. cit., p.154. See also S.R. Hirsch and J. Harris (eds.), Consent and the Incompetent Patient: Ethics, Law and Medicine, (1988), p.76.

15. I. Kennedy, "The Legal Effect of Requests by the Terminally ill and Aged not to receive further Treatment from Doctors", [1976] Crim.L.R. 217.

natural death legislation exists there is a danger that people will infer that a patient who has not signed a living will does not want life sustaining treatment to be ended under any circumstances.[16]

6.8 Despite the problems, the popularity of natural death legislation is evidence that the facility to make living wills is generally regarded in the U.S.A. as useful and desirable. However, the most significant benefit identified by the Report of the President's Commission was an indirect one: "the greatest value of the natural death acts is the impetus they provide for discussions between patients and practitioners about decisions to forego life sustaining treatment".[17] Other commentators have reached similar conclusions.[18]

6.9 There are, of course, significant differences between the situation in this country and that in the United States of America. The United States has a more profit-orientated hospital system which arguably calls for greater ethical safeguards. The medical profession in the United States has also shown a more marked tendency to attempt to preserve life at all costs.[19] Devices which

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16. President's Commission,(1983), op. cit., p.144.

17. Ibid., p.145.

18. Kapp, op. cit., at p.155 says "the living will provides a valuable incentive and opportunity for much needed dialogue... in this difficult and previously off-limits... [area]." See also M. Klutch, "Survey Result After One Year's Experience with the Natural Death Act", (1978) 28 West J. Med. 329.

19. A. McCall Smith, "Committee Ethics? Clinical Ethics Committees and their Introduction in the United Kingdom", (1990) 17 J. Law and Society 124.

prove worthwhile in the United States will not necessarily transfer across the Atlantic equally successfully. The introduction of living wills, and variations upon them, in this country has recently been considered by several groups. The British Medical Association has concluded that a living will is, and should be, no more than a clear and settled indication of the patient's wishes which should nevertheless be regarded with the utmost respect.[20] Elsewhere a more positive role has been advocated for them,[21] and in a recent publication, Age Concern has provided a concise precedent for a living will.[22] Clearly, this is a sensitive matter, related to the controversial subject of euthanasia, which , despite a number of attempts, has never been legalised in this country.[23] The experience in the U.S.A. suggests, however, that although living wills are not without their problems, they can have a valuable role to play.

(c) "Springing" or contingent powers of attorney

6.10 Springing powers of attorney have been developed as a refinement of the enduring, or, as they are generally known in America, "durable" power of attorney.[24] Enduring

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20. British Medical Association, Euthanasia, (1988), p. 58.

21. Age Concern and the Centre for Medical Law and Ethics of Kings College, op. cit., pp. 80-81.

22. Age Concern, The Law and Vulnerable Elderly People, (1986), p.70.

23. Lush, op. cit., at p. 22.

24. Legislation enacting the springing power of attorney has been implemented in New York and is under consideration in British Columbia. For a discussion of the subject, see Law Reform Commission of British Columbia, Report on the Enduring Power of Attorney: Fine Tuning the Concept, (1990).

powers of attorney not only enable the attorney to act after his principal becomes incapacitated, but also permit him to do so before the event. It has been suggested that some would-be principals are uncomfortable at the prospect of conferring authority on an attorney which has the potential to be exercised before it is needed; they might be more likely to provide for the future by executing an enduring power of attorney if, like a will, it simply remained dormant until required.[25] The springing power of attorney meets this need by making it a provision of the power that it shall not have legal effect until a specified contingency occurs. Such a contingency would normally be the incapacity of the principal, but might be any other event for which he wished to provide.[26]

6.11 Although the Enduring Powers of Attorney Act 1985 does not explicitly endorse springing powers of attorney in this country, a would-be principal can achieve the same result under the general law of contract and agency by including in the appointment a condition that it shall not come into effect until the happening of a specified event; the notes on the prescribed form of power expressly contemplate this possibility. One of the main practical obstacles anticipated in America was the difficulty experienced by third parties in determining whether the event "triggering" the operation of the power had occurred; this is unlikely to present the same problems here, at least when the triggering event is the incapacity of the principal, because of the requirement that the enduring

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25. Law Reform Commission of British Columbia, op. cit., p.9.

26. Ibid., p. 17 suggests someone whose business involves frequent visits to places where terrorist activity is common. A springing power of attorney might come into effect upon being taken hostage.

power of attorney be registered at the Court of Protection.[27] Specific legislation might, however, have advantages as it would put the legal acceptability of springing powers of attorney beyond doubt, and encourage their wider use as part of the normal arrangements for putting one's affairs in order.

(d) Springing or enduring powers of attorney for health care

6.12 This is a further refinement of the enduring power of attorney in which it is combined with the principle behind a living will. In the U.S.A., a number of natural death statutes expressly permit competent adults to choose a proxy to make life-sustaining treatment decisions for them if they become critically ill. This may be done as well as, or instead of executing a living will.[28] This approach has received strong endorsement from the President's Commission, which has also encouraged the extension of the principle to include authorising patients to provide for other less serious health care decisions.[29]

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27. Enduring Powers of Attorney Act 1985, s.4. Springing powers of attorney intended to come into operation on the happening of an event other than the incapacity of the principal would require some other form of verification, such as certification by a third party as adopted in New York. These matters are, however, outside the scope of this paper.

28. This was first introduced in Delaware in 1982, Del. Code Ann. Tit. 16, para. 2502(b).

29. President's Commission, op. cit., p.146: "durable power of attorney Acts offer a simple, flexible and powerful device for making health care decisions on behalf of mentally incapacitated patients".

6.13 Springing or enduring powers of attorney for health care have a number of advantages over living wills.[30] They are much more flexible, as it is unnecessary to anticipate all future medical needs before the onset of illness. The autonomy of the patient is enhanced as he is enabled to choose the person he most trusts to represent his views, and equally, to prevent critical decisions being made by someone he regards as unreliable. Another important feature is the automatic provision of an advocate for the incapacitated person who can persuade, argue and discuss on his behalf. Combining the enduring power of attorney with a living will would make available the advantages of both devices, and this has been suggested as the most satisfactory way of introducing advance directives in this country.[31] It would, however, require careful consideration of the present procedures and safeguards to see whether they were adequate to the attorney's expanded role.

(e) Advance nomination of a substitute decision-maker for personal care

6.14 It would be possible to expand the concept of the enduring power of attorney yet further, beyond health care decisions to include all or any decisions in relation to the principal's personal care. This would, in effect, enable the person concerned to nominate his own "guardian" before incapacity supervened. Such a power might be general or limited, and its possible applications would be virtually endless. It could, however, have potential to be particularly useful in certain areas, such as decisions relating to admission to residential care. If such a

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30. Kapp, op. cit., p.127.

31. Age Concern and the Centre of Medical Law and Ethics, op. cit., p.82.

development were to be considered, it would be important to look closely at the opportunities for abuse which could arise.

(f) Improving the enduring power of attorney scheme

6.15 Whether or not the potential scope of an enduring power of attorney is extended beyond the donor's "property and affairs", it may now be appropriate to reconsider some of the details of the scheme. A number of potential shortcomings in the operation of the Act have already been pointed out.[32] The efficacy of the present concentration of effort upon supervising registration at the point at which the patient becomes incapable is also questionable. The procedures are inflexible. They may require many distant relatives (who may not even know of the patient's existence) to be notified. At the same time, unscrupulous people can manipulate the procedure, for example, by omitting names of relatives from the form, with little chance of discovery. There is no way of ensuring that enduring powers of attorney are actually registered at all when the donor becomes incapable. It is quite possible that the mischief they were designed to prevent, that is, attorneys continuing to manage the affairs of mentally incapacitated people by virtue of invalid powers, is still continuing on a large scale. Powers of attorney were originally designed to deal with the affairs of people of full capacity. They were then adapted into what was intended to be a simple, effective and inexpensive way of handling the affairs of mentally incapacitated people, the present safeguards being introduced in the hope of providing sufficent supervision to prevent widespread abuse whilst

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32. See paras. 3.12-3.14 above.

avoiding the full expense of trusteeship or receivership.[33] Unfortunately, it is arguable that we now have an uneasy hybrid which is not particularly simple, effective or inexpensive and requires donors and honest attorneys to comply with a number of troublesome technicalities[34] whilst allowing rogues to evade detection with comparative ease.

6.16 There are two possible approaches to reform: the first would improve and develop the present structure of safeguards, the second would substantially reduce them or abandon them completely. The present safeguards may have room for improvement. It may be opportune to consider whether the registration system is serving any useful purpose in its present form, and whether alternatives, such as greater rigour and formality at the time of execution or a more comprehensive supervisory authority after the onset of incapacity, might be preferable. The second option, that of reducing or abandoning the present safeguards, would be in line with the approach adopted in Scotland and some commonwealth countries. Recent legislation in Scotland provides for ordinary powers of attorney to endure beyond the onset of mental incapacity without any special formalities, safeguards or institutional protection.[35]

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33. The Incapacitated Principal, Law Com. No. 122, Cmnd. 8977, (1983), pp.12-13.

34. The Australian Law Commission has said, "In the U.K. the scheme for enduring powers of attorney is so complicated that it is virtually impossible to use one without professional legal help". Enduring Powers of Attorney, Report No. 47, (1988), para. 14.

35. Law Reform (Miscellaneous Provisions) (Scotland) Act 1990, s.71. This appears to be intended as a stopgap provision only: see the circumstances under which the relevant clause was added as an amendment to the Bill on its way through Parliament. Hansard (H.C.), 17 October 1990, Vol. 177, cols. 1225-1227. The Scottish Law Commission is in the process of preparing a discussion paper, Personal and Financial Guardianship of Mentally

Other countries, whilst choosing a less extreme form, nevertheless show a similar preference for avoiding excessive formality and complexity. A recent report by the Alberta Law Reform Institute in Canada agreed with the conclusion of the Australian Law Reform Commission that the English scheme is "far too elaborate",[36] and considered that "the potential benefits of such a scheme cannot possibly justify the added complexity and expense which it imposes", also doubting "the importance of its underlying purpose, namely, to bring the existence of the EPA to the attention of the donor's relatives."[37] It is necessary to weigh the benefits of simplicity to the vast majority of donors and honest attorneys against the risks of abuse in a small minority of cases. A further problem, which could be tackled irrespective of the approach to procedural safeguards is the lack of any positive duties on an attorney to act. Many donors may believe that, by executing an enduring power of attorney, they have ensured that their affairs will be looked after and kept in order. But an attorney is not a trustee and there are no sanctions available against one who through inertia or uncertainty sits back and simply does nothing. This would be an even greater problem if the scope of enduring powers of attorney were extended to health and personal care decisions.

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35. Continued
Disabled Adults, which may recommend a different solution.

36. Australian Law Reform Commission, Enduring Powers of Attorney, Discussion Paper No. 33, (1987), p.8.

37. Alberta Law Reform Institute, Enduring Powers of Attorney, Report for Discussion No. 7, (1990), p.55. But cf. Law Reform Commission of the Republic of Ireland, Land Law and Conveyancing Law: (2) Enduring Powers of Attorney, Report No. 31, (1989), p.12, which describes the registration system operating in England as "highly satisfactory".

(a) Alternative decision-makers

6.17 In some areas, it would be possible to clarify and regularise mechanisms for taking certain decisions without any prior certification or commitment of the mentally incapacitated person. In its simplest form, this would be akin to the way the intestacy laws automatically prescribe who shall inherit the estate of someone who has not made a will. It would prescribe who should make certain decisions for someone unable to make them for himself. The choice of decision-maker could vary according to the type of decision, and might be a single individual, or a combination of people. Possible alternative decision-makers include the following.

6.18 **A decision-maker previously nominated by the person concerned.** This would allow many of the options discussed above, principally refinements of the enduring power of attorney, to be combined with this system. A representative personally chosen by the mentally incapacitated person could be given first priority, with the statutory scheme only coming into operation if no prior choice has been made.

6.19 **A representative already formally appointed such as a guardian or receiver.** Where a guardian or receiver has been appointed he may well be an appropriate person to make some decisions, but not necessarily all. Most people will not have or need a guardian or receiver.

6.20 **A responsible professional.** Examples might be the doctor proposing certain medical treatment, or the

social services department wishing to admit someone to residential care. There are obvious objections to resting the decision-making power with any single individual who is proposing a course of action, but it would be possible to include safeguards, such as requiring a second opinion or consultation with a multi-disciplinary team.

6.21 **The primary carer.** This may, or may not be a relative of the mentally incapacitated adult.[38] This would, in many of cases, be recognising the status quo and giving legitimacy to the substitute decision-making which already occurs on a day to day basis on everyday matters. There are many good reasons for this. The person caring for a mentally incapacitated adult generally has his well-being at heart and will be in the best position to know what his wishes and preferences are likely to be. However, there are some drawbacks. The carer's personal involvement may make it difficult to be objective and dispassionate. Long experience of looking after the person concerned may make the carer over-protective, and create a tendency to stifle, rather than encourage self-determination. There will be an occasional carer who acts in bad faith, and through motives of self-interest.

6.22 **The family.** This would include at least spouses, parents, adult children and siblings. Some method of ranking might be appropriate in the event of disputes,[39] but a close family can often reach a consensus; this may

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38. An important example of non-relatives are former foster parents of a mentally incapacitated young adult over 18, who has previously been in the care of the local authority. See para. 1.9(v) above.

39. Perhaps along the lines of the "nearest relative" definitions in Mental Health Act 1983, s. 26.

deserve recognition as a substitute decision-maker on behalf of one of its members. However, many people do not have any close family, or any family at all, or are estranged from them. Problems can also arise if family members are very closely involved emotionally in a particular situation, and they lack the professional skills and training which can aid dispassionate judgment.

6.23 **A combination of professional, primary carer and family.** In practice, many more serious decisions about health care or residence are taken by a combination of the relevant professional and the primary carer who is often a close relative. Indeed, this is the model upon which the Mental Health Act procedures have long been based, the only distinction being the degree of formality (or as it might be thought, regularity) involved.

6.24 **A court, tribunal or other authority.** Some decisions may be thought so serious that they should only be carried out with the prior approval of an independent court or tribunal. A common example is the approval of the High Court to the non-therapeutic sterilisation of mentally handicapped young women.[40] It would be possible for legislation to provide that certain decisions could only be made by a specialist tribunal or court. Examples in addition to sterilisation might be abortion or other serious medical procedures, the transfer or disposal of property over a certain value or the giving of consent in divorce proceedings. This would also provide a forum for resolving any disputes arising between joint decision-makers. The main differences between tribunals and courts have been

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40. See paras. 2.20, 2.21 above.

mentioned earlier.[41] The choice between a court or tribunal would depend, not only upon the degree of formality and procedural safeguards felt to be desirable, but also upon whether inquisitorial or adversarial procedures were most appropriate. In the former, the tribunal might make its own inquiries and use its own expertise in making a decision, whereas in the latter it would rely upon the evidence and arguments presented by opposing parties. One problem with the adversarial approach in this area is that, for many decisions in which an independent safeguard might be desirable, there are no opposing parties.

6.25 A further refinement, suggested in the U.S.A. in the context of medical treatment, is that someone (i.e. the doctor) is designated to choose a substitute decision-maker for a particular matter. In 1982, the President's Commission recommended that decisions about incapacity should be made at institutional level whenever possible, and that the validity of such determinations should be recognised by law.[42] The Commission considered it impossible to draw up a formula for selecting a substitute decision-maker which would be capable of capturing the complexities involved. Accordingly, they recommended that it should be the responsibility of the medical practitioner in each case to decide who knows the patient best and has his best interests in view, or to decide that there is no appropriate person and to apply to the court for the appointment of a guardian. [43]

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41. See para 5.27 above.

42. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research, Making Health Care Decisions: A Report on the Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship, Vol I, (1982), p.175.

43. Ibid., p.182.

(b) Substitute consent to treatment procedures

6.26 A particular area for prescribed decision-making without legal formalities is that of consent to medical treatment. Statute might regulate who could decide on most medical treatment for people unable themselves to give a valid consent. A number of models are possible. The scheme might be on similar lines to that contained in Part IV of the Mental Health Act 1983. This contains different safeguards for different types of treatment.[44] Certain particularly controversial treatments, currently the surgical destruction of brain tissue or implantation of hormones to control the male sex drive,[45] require not only the patient's consent but also (i) a certificate from an independent doctor appointed by the Mental Health Act Commission and two other people that the patient understands the purpose and nature of the treatment and consents to it, and (ii) a certificate from the independent doctor, who must consult a nurse and a non-medical professional who has been involved with the patient, that the treatment should be given.[46] Certain other treatments, currently electro-convulsive therapy or the continuation of drug treatment for more than three months, require either the patient's consent or an independent second opinion.[47] Otherwise, most detained patients can be treated for their mental disorders (but not for their physical illnesses)

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44. See para. 2.25 above.

45. Mental Health Act 1983, s.57(1); Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983, S.I. 1983/893, reg. 16(1)(a).

46. Ibid., s.57(2).

47. Ibid., s.58; Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983, S.I. 1883/893, reg.16(2)(a).

without their consent.[48] There are various additional safeguards requiring reports upon the treatment and condition of the patient to be provided to the Mental Health Act Commission, providing for the treatment to be reviewed and prescribing the form in which certificates are to be given.[49]

6.27 Some features of this scheme, such as the hierarchy of proposed treatments and the provision of independent second opinions by a specialist body like the Mental Health Act Commission, might usefully be adapted to provide for consent to treatment on behalf of mentally incapacitated adults. Where a procedure is being used because there is by definition doubt about a patient's ability to consent, arrangements for obtaining such consent are clearly redundant. However, there might be merit, particularly for more serious medical treatment, in requiring a doctor or psychologist to certify that he has interviewed the patient and conducted a test of competence,[50] as a consequence of which he considers that the patient is unable to give a valid consent but that in so far as the patient comprehends the situation, he has raised no objection to the proposed treatment.[51] Various refinements might be added to this requiring consultation with carers, social workers or other health care professionals for certain categories of treatment, or in cases where, although considered incompetent, the patient <u>has</u> raised an objection to the

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48. <u>Ibid</u>., s.63.

49. <u>Ibid</u>., ss. 61, 64(2).

50. Perhaps a test similar to those described in paras. 2.38 and 2.40 above.

51. There is a parallel to this in the new German legislation. See para. 5.22 above.

proposed treatment. Second medical opinions might be required from appropriately qualified doctors for certain categories of treatment. Also, the status of the doctor giving the certificate might vary according to the category of treatment or the degree of difficulty in assessing whether or not the patient is able to consent. For example, a certificate from the patient's G.P. might suffice for the administration of antibiotics for an infection, whereas that of a consultant cardiologist might be required (perhaps together with a second opinion and the consent of a relative or carer) for a coronary by-pass or heart transplant operation. In cases where serious treatment is being contemplated, and the patient's capacity is a borderline question, it might be appropriate for a certificate to be given by a psychiatrist.

6.28 Another scheme has been proposed in a report by MENCAP.[52] This recommends that decisions should be made by the individual's most appropriate relative together with the doctor proposing the treatment. Where there is no appropriate relative, it is suggested that a carer, friend, social worker or other suitably qualified professional could be substituted. In the event of disagreement, MENCAP envisage the case being referred to a locally constituted multi-disciplinary Ethics Committee, which would initially attempt to resolve the disagreement but would in the last resort be entitled to take the decision itself. These proposals also envisage particularly serious treatments[53]

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52. Report of the Working Party on the Legal, Medical and Ethical Issues of Mental Handicap of The Royal Society for Mentally Handicapped Children and Adults (MENCAP), Competency and Consent to Medical Treatment, (1989).

53. "Serious treatments" include sterilisation, some hysterectomies, termination of pregnancy, some plastic surgery, prescription of major psychotropic medication and administration or withholding of life sustaining treatment. MENCAP, op. cit., Appendix 3.

being referred automatically to the Ethics Committee, and to the Committee being required to consider such cases in accordance with specific guidelines.

6.29 The British Medical Association has recently published proposals for a similar decision-making procedure.[54] These suggest that a new committee should be established in each health district with the legal authority to act on behalf of any mentally incapable adult seeking or being brought for investigation or treatment in that area. It is envisaged that these committees would have at least four members from diverse backgrounds who would be appointed for a fixed period of five years, on an expenses only basis, by the Secretary of State for Health on the advice of the Mental Health Act Commission. The decisions which have to be made would be divided into three tiers. First level decisions, being simple treatment or diagnostic options involving no controversy, would be left to the medical attendant in consultation with the people providing the patient's environment; the more serious the decision, the more consultation there should be. In the case of second level decisions, relating to matters such as elective surgery of a simple nature or the use of drugs with milder side effects, a member of the committee would act on the patient's behalf, to ask questions, receive explanations and give or withold consent. The full committee would review regularly decisions made by its individual members and adjudicate when there was any dispute about first or second level decisions. It would also take all third level decisions relating to any treatment which is not

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54. British Medical Association Medical Ethics Committee and Mental Health Committee, Proposals for the Establishment of a Decision-making Procedure on behalf of the Mentally Incapable, (1991).

straightforward or has significant side effects.[55] The committee would be expected to take into account the views and wishes of relatives and carers and the patient's social and cultural background. It would be able to seek a second medical opinion when necessary, and have power to refer a case to the High Court if it could not decide. Other interested parties would also be able to appeal to the High Court if they disagreed with the decision. Overview support and guidance would be provided for the committees by the Mental Health Act Commission.

(c) Extended minority

6.30 Schemes for an extended minority for mentally incapacitated adults would give recognition to a legal role for parents or guardians of mentally handicapped children beyond the age of 18. The extended minority period might be quite short, say to 21, or considerably longer. This proposal is generally popular with parents and carers who would often prefer decision-making to remain in their hands, and certainly have legitimate claims to be heard in this respect.[56] But a balance needs to be struck between these, and the need to encourage autonomy in mentally handicapped young adults. The concept of extended minority does not sit very comfortably with a flexible and functional notion of capacity, as, at least in part, it means applying a status test. It is also open to the philosophical

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55. These would include aortography, HIV testing, treatment relating to fertility or pregnancy, major surgical procedures with risk to life, treatment options in patients with terminal illness or any research procedures. Ibid.

56. National Society for Mentally Handicapped People in Residential Care (RESCARE), Bulletin No.1 The Law and People with a Mental Handicap - "Extended Minority", (1989).

objection that, as mentally handicapped adults are not children, treating them as such is the wrong approach. But it might be possible to adapt the idea, after exploring ways in which the two groups differ, and the appropriate distinctions in the laws which should apply to them.

6.31 In introducing any reform along these lines, it would be necessary to provide a mechanism for deciding to whom an extended minority would apply. This might be a matter for adjudication, requiring an application to some form of court or tribunal, or a matter of medical judgment, for example on the certificate of two doctors that the person concerned meets certain specified criteria. It would also be necessary to decide who should take, or what should prompt, the initiative to invoke the procedure, and whether there should be a right of appeal to a court, or perhaps to a specialist tribunal. It would be possible for the court or tribunal also to have power to resolve disputes, for example, between parents over where their child should live, or who should have access to him. Alternatively, provision might be made for such matters be dealt with under the child care or matrimonial legislation. Other questions concern the extent of parental responsibilities. Should they continue in full, including, for example, the power to appoint a testamentary guardian, or would some curtailment be appropriate? One possible option might be to equate parental responsibilities under an extended minority with those of a guardian under an adapted form of Mental Health Act guardianship. Thus, mentally incapacitated young adults who met certain criteria might be subject to their parents' guardianship for a fixed period after attaining the age of 18, but the need for this would be reviewed at the expiry of that period.

Improve Existing Procedures

6.32 Most existing substitute decision-making procedures involve granting authority to someone else to take decisions on behalf of the mentally incapacitated person in individual cases. The operation of many of these might well be improved.

(a) Reformed crisis intervention measures

6.33 It would be possible to devise a simple protective mechanism to allow intervention to protect a vulnerable adult from neglect or abuse. One option has been suggested by Age Concern.[57] This proposes an Emergency Intervention Order available in exceptional circumstances when immediate action is needed to relieve a situation of immediate grave risk. It would be for a maximum period of seven days, renewable for seven days once only. The order could direct that specific help be brought to the person concerned where he resides, or that he be removed to a place of safety. Alternatively, a non-molestation order or exclusion order could be granted against named individuals. Such a procedure could stand alone, or be a "bolt-on" option to a wider statutory scheme. Various features would need to be developed differently depending on the choice made, but in either case, the starting point could be the provisions of National Assistance Act 1948, section 47, and Mental Health Act 1983, section 135. The aim would be to revise and combine these powers to eliminate, as far as possible, most of the obstacles to their effective operation.[58]

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57. Op. cit., pp.135-136.

58. These obstacles are discussed in para. 3.23 above.

6.34 Matters requiring particular attention include the following. There should be a clear allocation of responsibility for invoking the procedure as between health authorities and social services. It might serve to reduce confusion if the model of the Mental Health Act were used, in which the application is made by a social worker on the recommendation of one or two doctors. The criteria should also be simplified and clarified; however, the 1948 Act at present includes certain people who are not mentally incapacitated and consideration would have to be given to how far, if at all, it was appropriate to include them in any reformulated scheme.

6.35 Consideration would have to be given to the most appropriate forum to which an application should be made. There is much to be said in favour of magistrates' courts in terms of speed and ease of access. They also have experience with comparable procedures such as applications for place of safety orders (and shortly, emergency protection orders) for children. Conversely, there may be a danger of inconsistency in the standards applied by different courts, with little opportunity for individual justices to acquire expertise, and a greater stigma for the person concerned than there is with non-court based procedures. Mental Health Review Tribunals have greater expertise and may involve less stigma, but are organised at present to review decisions already made rather than to authorise them in advance. They do not sit every day in readily accessible places. Nevertheless, a specialist tribunal may be the appropriate forum for many of the issues discussed here, including emergency protection.[59] Workable

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59. In Victoria Australia, emergency powers are exercised by the Guardianship and Administration Board. See para. 5.7 above.

but not too onerous procedural safeguards would be needed for the people concerned. In particular, there should be provision for representation and mechanisms for a rapid review of any orders made. In view of the emergency nature of the proceedings, fairly strict time limits may be appropriate. It would also be helpful to clarify the allocation of responsibility for the person concerned, once protective measures had been implemented, particularly in areas such as consent to medical treatment.

(b) Expanding the scope of guardianship within present procedures

6.36 It would be possible to reform the present guardianship legislation to eliminate the more serious shortcomings, clarify ambiguities and uncertainties and close loopholes. For example, unnecessary restrictions upon the application of the present law could be removed by extending the categories of people who may be admitted into guardianship. A simple way of achieving this would be to remove the requirement that the patient must exhibit "abnormally aggressive" or "seriously irresponsible" conduct in addition to mental handicap.[60] Guardianship could also be made more useful as a tool for intervening in and averting crises by removing the nearest relative's right of veto,[61] at least in the short term. The powers of a guardian could also be extended to allow the guardian to consent to certain kinds of medical treatment, provided that the patient does not actively object. There would be difficulties in administering and supervising forcible treatment against the patient's will, and there is much to

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60. See para. 3.30 above. Also, M.J. Gunn, "Mental Health Act Guardianship. Where Now?", [1986] J.S.W.L. 144.

61. Mental Health Act, 1983, s.11(4); see para 3.34 above.

be said for restricting this to a hospital setting, where it can be properly monitored.

6.37 Efforts might be made to improve the "image" and acceptability of guardianship by providing a clearer explanation of the purposes for which it is intended. The 1990 Code of Practice to the Mental Health Act 1983 gives a brief definition of the purpose of guardianship,[62] but this is in rather vague terms and the intention behind it has certainly been imperfectly appreciated in the past.[63] Reviews of guardianship have concluded that its use has been bedevilled by uncertainty about and unfamiliarity with its procedures, and inconsistency in its application.[64] The resources required to administer it might be reduced by relying on regular review rather than social services supervision in every case. Accessibility might be increased by allowing either the social services authority or the health authority to assume responsibility, depending upon which was the more appropriate in the particular case. This would reflect the continuing heavy involvement of the health service with mentally handicapped and disordered people, although it would run counter to the trend in community care generally. The problems might also be

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62. At para. 13.1. See para. 3.24 above.

63. There is, for example, evidence to suggest that the main use made of guardianship by some local authorities has been to facilitate the admission of elderly or handicapped people into residential care without their consent. This is the direct opposite of the purpose expressed in the 1990 Code of Practice. T. Leckie and P. Proctor, "Should Guardianship Orders be Used to Deal with Cases of Dementia?", Social Work Today, 31 August 1987, p.8. See also Mental Health Act Commission, First Biennial Report (1983-5), para. 8.5(b).

64. S. Millington, Social Work Monographs: Guardianship and the Mental Health Act 1983, (1989); Gunn, op. cit.

alleviated by procedures and guidelines being worked out at national and local levels, and better liaison about the use of guardianship between hospital and community-based staff in both health and social services.[65]

(c) Expansion of the role of the Court of Protection

6.38 The main object of expanding the powers of the Court of Protection would be to make it more flexible and easier to use. These aims might be achieved to varying degrees, depending on the extent of the expansion envisaged. Limited reforms might include extending the role of the court and the receiver to cover certain decisions about the personal care and welfare of patients, including, perhaps, their place of residence and certain forms of medical treatment. If the idea of an enduring power of attorney for health care were to be adopted, the court might be developed into a suitable supervisory body, in a similar way to that in which it already supervises enduring powers of attorney in relation to property matters. If it were felt appropriate for decisions about serious or controversial medical treatment to be made by a High Court judge, the Court of Protection already has access to the High Court through the nominated judge procedure, although it might be preferable for Family Division, rather than Chancery Division, judges to be nominated for this purpose.

6.39 The court's procedures might be revised to provide a greater degree of "due process". More emphasis might be put on the quality of the medical evidence relied upon, with provision being made for this to be supplemented by lay assessments of social competence, where these would prove

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65. Age Concern, op. cit., p.90.

helpful. There is also scope for improvements to be made in the giving of notice of and explanations about proceedings to patients. In some circumstances it might be appropriate for such notice to be given in the form of an oral explanation by a sympathetic friend or social worker. This would also make it easier for the patient to raise queries or objections. More effort could be made to assess people's competence to continue to act for themselves in some areas, so that "partial" receiverships, in which the powers of the receiver are more closely tailored by the order appointing him to the needs of the individual patient, might be introduced and developed. A criterion of "need" could be introduced into the test of incapacity, so that receivers are not appointed in cases where the needs of the patient can be met in other ways. It would also be possible to provide for regular, automatic reviews of the need for receivership, so that the burden of applying for its discharge did not necessarily always lie on the patient. The Short Procedure Order process might be expanded to enable the Court to deal with small estates with the minimum of formality and expense, and consideration might be given to a wider use of the court's power to waive fees.

6.40 Alternatively, it would be possible to use the existing structure of the Court of Protection as the basis for a more radical reform. Under this it might become the central adjudicative and supervisory body ultimately responsible for all personal welfare or property and financial decision-making on behalf of mentally incapacitated adults.[66] This would require a radical restructuring and refinancing of the court's operations, which could no longer be paid for entirely from the estates of mentally incapacitated people themselves. It would also

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66. Offered as a suggestion by Age Concern, op. cit., p.85.

require careful consideration of the boundaries between the court's role and those of Mental Health Review Tribunals and the Mental Health Act Commission. Regional offices would have an important part to play in making such a service more accessible and responsive to local needs. They would also make it easier and more practicable for the Court of Protection to assume the present jurisdiction of the magistrates' courts in relation to crisis intervention measures. The practical consequences of a radical reform and extension of the jurisdiction of the Court of Protection might be simply another way of introducing comprehensive guardianship laws.

Decision-making by a Multi-disciplinary Committee or Tribunal

6.41 A number of recent reviews of decision-making on behalf of different groups of mentally incapacitated people have suggested the multi-disciplinary tribunal as a desirable forum. The object of this would be to provide a single forum which would be capable of handling every type of decision. The precise proposals vary, but they all aim to provide a flexible, single door procedure which enables expertise from a number of different disciplines to be brought to bear upon the particuiar problem quickly and without undue procedural obstacles or expense.

6.42 In some instances, for example, the use of Ethics Committees proposed by MENCAP, the multi-disciplinary "tribunal" is seen as a long-stop, which is only brought into operation when disagreement arises amongst primary decision-makers, or when particularly important matters fall

to be decided.[67] The general objectives of the Ethics Committee would be to reach decisions dispassionately, to consider competently all the relevant factors in a particular case, to be small enough to take decisions, but large enough to ensure that a sufficient number of different perspectives contribute to the decision-making process. For this purpose, a quorum of five members is suggested, including at least two non-health care professionals.[68]

6.43 It might be possible to develop the idea of graduated decision-making by authorised people, with a multi-disciplinary Committee as a long stop, beyond the area of consent to treatment, to encompass other categories of decision-making on behalf of mentally incapacitated people.[69] Such a forum might be particularly well suited to making decisions upon issues such as admission to

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67. MENCAP, op. cit., p.15. See para. 6.28 above.

68. Ibid., Appendix 2 gives a suggested composition for the Ethics Committee to be drawn from the following: a consultant psychiatrist in mental handicap, a representative from the Social Services Department Mental Handicap service, a psychologist, a social worker or community nurse, a medical consultant from a relevant speciality, a representative from a local advocacy group or voluntary organisation, a parent, carer, friend or advocate, an informed non-health care professional such as a chaplain, a general practitioner.

69. One proposal along these lines has been forwarded to the Commission by a Sub-Committee formed by Surrey MENCAP County Group. These proposals envisage the creation of three categories of decision, those able to be made by the mentally incapacitated person himself, those to be made by a guardian and serious matters or major disagreements between the person concerned and his guardian, which could only be decided by a "Safeguards Committee". Guardianship would be administered by the local authority, and the guardian would normally be a relative, friend or representative of a charitable organisation appointed for a renewable term of three years. The Safeguards Committee would be convened and administered by the local authority and have

residential care, or the provision of domiciliary services.[70] Codes of Practice could be drawn up to give guidance upon how decisions should be taken, and the criteria for determining incapacity.

6.44 One detailed proposal was made in Scotland by the Rights and Legal Protection Sub-Committee of Scottish Action on Dementia.[71] This recommends a totally new procedure, modelled upon the Scottish system of children's hearings. The aim is "to combine simplicity of access with thorough and sensitive investigation, liaison with relatives and professional workers, comprehensive decision-making powers, community involvement and regular reviews".[72] It envisages the establishment of regional Mental Health Panels, with unpaid members who would be chosen for their interest in or experience of the problems of mental disorder. A Mental Health Reporter, with an appropriate number of deputies, would be appointed for each area. The Reporter would be obliged to act on information from any source suggesting that a person or his property might be at risk. He would make initial investigations, have power to call for medical or social work reports, and assess the person's mental state and abilities to establish the extent of his incapacity.

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69. Continued
multidisciplinary composition. It would have a minimum of three and a maximum of five members, with an appeal procedure to the courts, or to a specialist appeal board.

70. Multi-disciplinary consideration of admission to residential homes is one of the reforms advocated by Age Concern op. cit., p.56, and The Law Society's Mental Health Sub-Committee, Decision-making and Mental Incapacity: A Discussion Document, (1988), p.7.

71. Scottish Action on Dementia, Dementia and the Law: The Challenge Ahead - a proposal for action, (1988).

72. Ibid., para. 4.5, p.19.

He might decide to take no action on a case, but if certain conditions were satisfied and he believed compulsory measures to be justified, he would be obliged to refer the case for a Hearing. These conditions would cover cases where because of incapacity, a person was exposed to danger, unable to manage his property or financial affairs, or risking damage to his health or welfare. The Reporter would also have emergency powers, enabling him, after observing certain safeguards, to order a person's removal to a place of safety or to take steps for the protection of his property.

6.45 Hearings would take place before three members of the Mental Health Panel. There would be procedural requirements governing the constitution of the tribunal, those entitled to attend and representation of the person concerned, and each Hearing would be served by a legal assessor whose function was to advise on matters of law. The Hearing would consider what required to be done on behalf of the incapacitated person, and whether any of its powers should be exercised. These powers would be extensive, and would include orders for supervision by the social work department, consent to medical treatment, admission to residential care, and orders in relation to property or finance, including the appointment of a curator where long term substitute management was required. Where necessary, the Hearing would also be able to appoint a guardian with general or specific powers. Rights of appeal to the sheriff court would exist, and where the Hearing's decision took effect, the Reporter would be obliged to arrange for regular reviews of the case to take place.

6.46 The Hearings system has no real equivalent south of the border, although the Mental Health Review Tribunals,[73] already provide a comparatively inexpensive expert multi-disciplinary forum for reviewing the need for continued detention and guardianship under the Mental Health Act 1983. As with the Court of Protection, however, they would require considerable expansion and adaptation to be capable of handling every type of decision-making on behalf of mentally incapacitated people.

Advocacy

6.47 In recent years, advocacy has been recognised as having a potentially important part to play in assisting mentally incapacitated people to make choices and exercise their rights. An advocate is someone, perhaps a relative, a volunteer or a professional, who undertakes the responsibility of explaining the situation from the patient's point of view, rather than assuming authority over him.[74] This may involve pleading his cause and generally taking such action as may be necessary on his behalf to secure the services he requires and enabling him to enjoy his civil and legal rights to the full. Three forms of advocacy are generally recognised:[75]

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73. Mental Health Act 1983, ss.65-79.

74. W. Bingley, "The Mentally Handicapped Person as Citizen: The Law and Advocacy", in E. Alves (ed.), Issues in Criminological and Legal Psychology: Mental Handicap and the Law, (1987), p.16; Gunn, op. cit., p.151.

75. Ibid., p.21. See, however, S.S. Herr, Rights and Advocacy for Retarded People, (1983), pp.213-219 where seven forms of advocacy are identified; self advocacy, family advocacy, friend advocacy, disability rights advocacy, human rights advocacy committees, internal advocacy and legal advocacy.

(i) **self-advocacy** where disabled people express their own needs and assert their own rights to the extent of their capabilities;

(ii) **citizen advocacy** where volunteers and co-ordinating staff, independent of those who provide direct services to disabled people, give general help and friendship in whatever ways may be needed by the mentally incapacitated person;

(iii) **legal advocacy** by which lawyers or trained lay representatives assist people with mental incapacity to exercise or defend their legal rights, either by casework, by scrutiny and monitoring of legislation and regulations, or by representation before courts, tribunals and other agencies.

6.48 Attempts have been made to establish advocacy schemes in this country[76], but the movement is still at an embryonic stage, and there is nothing like an independent national service available. There is a fundamental problem in finding enough people willing to carry out advocacy and in obtaining the resources to organise it.[77] Support for the idea is, nevertheless, growing. The Disabled Persons (Services, Consultation and Representation) Act 1986 provides for the Secretary of State for Health to make regulations authorising or requiring local authorities to appoint representatives for disabled people who are unable

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76. e.g. Advocacy Alliance, and the Springfield Legal Advice and Representation Project started in 1982. The main field of operation has been long-stay hospitals.

77. e.g. W. Booth, "Dependent, Frustrated and Devalued", Community Care, 13 December 1990, p.23-5.

to choose their own.[78] There are various provisions requiring local authorities to deal with representatives,[79] to supply them with information,[80] and grant access to the disabled person if he is in local authority or various other forms of residential accommodation.[81] The Act also imposes duties in relation to the assessment and consideration of the needs of disabled people, particularly on leaving special education or mental hospital.[82] There has been a good deal of criticism of the fact that much of the Act is not yet in operation.[83] The Department has carried out a consultation exercise with local authorities upon the implementation of sections 1, 2 and 3, those mainly concerned with advocacy, and further decisions are now awaited.

6.49 Advocacy schemes form an important part of provision for mentally disordered people in other jurisdictions, such as the special representative in Sweden[84] and the Public Advocate and Community Visitors

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78. Disabled Persons (Services, Consultation and Representation) Act 1986, s.1.

79. Ibid., s.2(1).

80. Ibid., s.2(2).

81. Ibid., s.2(5).

82. Ibid., ss. 3, 4.

83. D. Parratt, "The Disabled Persons Act 1986: Reality or Myth?", Contact, Summer 1989, p.13; D. Carson, "Disabled Persons (Services, Consultation and Representation) Act 1986", [1986] J.S.W.L. 362; Children's Legal Centre, "Implement the Disabled Persons Act now!", (1987) 36 Childright .

84. See para. 5.14 above.

scheme in Victoria, Australia.[85] Encouragement and development of this concept by providing it with a firm but flexible legal framework could form part of a package for reform.

A New Statutory Institution

6.50 Modernised guardianship schemes are becoming increasingly popular in other countries. In countries which have adopted them, they are seen as the best response to the inadequacies of the common law, such as gaps, cost and inflexibility, and as the most appropriate way of providing the machinery to resolve many contemporary problems facing mentally incapacitated adults and of reconciling the authority and paternalism involved in substitute decision-making with the power to insist that certain services are provided. As has been demonstrated, they share many common features.[86] There are also differences of approach which stem from a number of influences, including factors peculiar to a particular jurisdiction and the relative importance allocated to competing policy considerations.

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85. The Annual Report of the Office of the Public Advocate 1988, identifies two forms of advocacy undertaken by it, individual advocacy in the course of its casework, p.10, and systemic advocacy aimed at changing flawed policies and procedures adopted by agencies interacting with people with disabilities, p.22. The latter reflects "policy, program or organisational deficiencies, or alternatively, the need for change in the style or manner of a public or private organisation". The Community Visitors are volunteers appointed on a regional basis who visit facilities for disabled people and enquire into issues such as the adequacy and standard of services provided and the care and treatment that residents receive.

86. See paras. 5.23-5.29 above.

6.51 A number of calls have been made in this country in recent years for the introduction of new guardianship laws.[87] The term "guardianship" has become to some extent a weasel word, meaning all things to all people, as perceptions of the purpose and function of guardianship vary widely and are often irreconcilable.[88] For example, guardianship is sometimes seen as a device for providing guidance and counselling to people who may have the mental capacity to form certain legal relationships, but exercise this in a way which is seen as being contrary to their own interests. For others, it would be seen as completely inappropriate in such circumstances, the real need being for advocacy and better social services. Again, it has been suggested that guardianship should be adapted to create a better way of dealing with crisis management and emergency intervention. Another view sees guardianship as inherently too slow to adapt to this, a better way of dealing with emergencies being to use the criminal law, or specifically designed emergency powers legislation. It may also be argued that any comprehensive adult guardianship law is restrictive of the right of mentally incapacitated adults to be treated like ordinary people. Such arguments say that what is needed are better services, assistance and advocacy. At the root of these disagreements is the difficulty that allowing one person to take decisions on behalf of another is inevitably seen as giving that person a degree of

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87. Examples include Gunn, op. cit.; Millington, op. cit.; The Law Society's Group for the Welfare of People with a Mental Handicap which has produced draft guardianship legislation; L. Gostin, The Court of Protection - a legal and policy analysis of Guardianship of the Estate, (1983); British Association of Social Workers "Concern Mounts over the Use of Guardianship", Social Work Today, 15 July 1985, p.18; Age Concern, op. cit., p.91.

88. P. McLaughlin, Guardianship of the Person, (1979), pp.53-70; D. Carson, "Take the best and leave the rest", Health Service Journal, 22 March 1990.

authority over the other and it is difficult to see how this can be avoided. The fundamental question, perhaps, is whether any system intended to help mentally incapacitated adults should ultimately be subject to some form of judicial control.[89]

6.52 The principal object of any new scheme would be to avoid the gaps, fragmentation and confusion of responsibility which exist under the present law. It would provide a means, either of taking particular decisions on behalf of a mentally incapacitated person, or of appointing someone else to do so.

6.53 The aims and principles behind the scheme would have to be articulated and reflected in its design.[90] It is assumed, however, that these would include a presumption of capacity, together with intervention which was flexible, limited and tailored to the needs of the particular person concerned. Thus, only those decisions which the person was unable to take for himself but required to have taken for him would be involved.

6.54 A decision would first have to be taken upon whether there are any good reasons for perpetuating the present distinction between property and personal welfare, or whether the two are frequently so interrelated that, logically, a new institution should have power to deal with

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89. Whether by a court or a specialist tribunal or panel.

90. See paras. 4.17-4.23 above. See also, on the role of objects and principles clauses T. Carney, "The Limits and Social Legacy of Guardianship in Australia", (1989) 18 Fed. L.R. 231, 237-240.

both so that it can take overall responsibility for personal, legal and financial affairs. The latter course would necessarily involve incorporating within its structure the jurisdiction at present exercised by the Court of Protection.

6.55 A test of capacity would be required to define the categories of people who might be covered by the new scheme. A test frequently used in other common law jurisdictions is the three-fold test of disability, functional incapacity and need for a guardian.[91] The main objection to this, from a civil liberties point of view, is that the catchment is being extended to include people who may not suffer from any defined mental disorder and would not have been covered by earlier legislation. On one view, this may not matter and may even be an advantage if the functional incapacity and need criteria are strictly applied, so that guardians are only appointed where there is no satisfactory alternative. A test of this nature has a good deal to commend it in principle, in that it does not single out a particular form of disability for special treatment. However, there is a risk that functional capacity may be judged more on the quality of the person's decisions rather than on whether or not he has the understanding required to make them.

6.56 It would also be necessary to choose between the different procedural models represented by the Court of Protection and guardianship under the Mental Health Act 1983. The former relies on prior application to a court, supported by medical evidence, and (usually) notified to the person concerned, who has an opportunity to object. The

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91. See, for example paras. 5.4, 5.7 and 5.11 above.

latter relies upon the combined assessments of a specialist social worker and two doctors, accepted by the local social services authority, and subject to later review by a Mental Health Review Tribunal. The latter is felt by many to be quicker, cheaper, less stigmatising and a greater protection for the patient than the more conventional procedures of a court. It is assumed, however, that some form of judicial review would be required.

6.57 A choice then exists between a court or tribunal based system. The respective merits of the two have been previously discussed.[92] A court based system might be grafted onto the existing structure of the Court of Protection, with the Public Trustee continuing to provide administrative support and act as receiver and guardian of last resort. A multi-disciplinary tribunal with expertise in mental health matters already exists in the form of the Mental Health Review Tribunals. These are at present regionally based, and lack any central organisation, or full time judicial officers. Adopting a tribunal model might involve a more inquisitorial approach, with the tribunal making its own enquiries and deciding upon the evidence it needs to see. It might also be necessary, to enable the tribunal to carry out its duties, to provide it with its own investigative staff or social workers.[93] Legal input might be provided either by retaining a legally qualified chairman in every case, or by having a legally qualified clerk to advise the tribunal when needed. One possible option might be to combine features of both bodies, to provide one single adjudicative body with jurisdiction over all mental health matters.

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92. See para. 5.27 above.

93. As in Victoria and New South Wales, Australia where tribunal based systems exist.

6.58 There would be a role for an advocate of last resort, which might be extended into a public watch-dog or even community educator. The role of advocate of last resort is at present filled by the Official Solicitor who would be the obvious candidate for additional responsibilities in this area. The other existing body with related interests is the Mental Health Act Commission. Areas of responsibility would have to be worked out between them. Alternatively, the Official Solicitor and the Mental Health Act Commission might be brought under the same umbrella, much as the Public Advocate and the Community Visitors in Victoria.

6.59 A comprehensive scheme would normally include provision for emergency action and crisis intervention. However, this is a discrete area, and it would be possible, although perhaps less desirable on the ground of consistency, to make separate provision for this. A guardianship court or tribunal, with regional offices, and specialist judicial officers, would probably be the best possible forum.

6.60 Consideration should also be given to which matters are so personal, or of such special significance, that no substitute decision-maker should be allowed to decide them. Obvious examples are voting in elections, or marriage. A special procedure might also be needed whereby the court or tribunal could be asked to decide upon issues which are considered to be too difficult or controversial to be left to a guardian alone. The main examples of this are serious medical treatments such as non-therapeutic sterilisation, abortion or tissue donation.

6.61 Terminology would need consideration. In some ways it would be advantageous to give a new institution a new title to make it clearly distinct from the old form of guardianship. There is, however, no obvious choice, as many alternative titles are already used elsewhere, have undesirable connotations or are rather obscure and old-fashioned. There is also considerable force in the argument that the title "guardianship" is widely understood and anything else would sound contrived. But possible alternatives to "guardian" or "receiver" include warden, custodian, curator, caretaker, proxy, proctor, agent (and variations on this such as personal agent), manager, steward, factor or sponsor. Possible alternatives to "patient" include ward, principal, protege, or client.

PART VII

CONCLUSION

7.1 This paper forms the preliminary stage of our investigation into the adequacy of legal and other mechanisms for making decisions on behalf of mentally incapacitated adults. Its aim has been, not to look at any aspects in particular depth, but to provide an overview of the entire field in an attempt to gauge its magnitude and supply a basis for discussion about the way forward. We are conscious that many problems experienced in this area are not exclusively legal problems and may not be susceptible to a legal solution.

7.2 For this reason, we place great emphasis on the importance of extensive consultation, and welcome comments, criticism, suggestions and further information from anyone with a point of view to contribute. We envisage that the responses we receive will to a large extent dictate the future course of this project. We conclude by summarising below some of the main issues upon which we invite comment. These are not, however, intended to be exhaustive, and we welcome additional responses upon any other relevant matters.

(1) Is reform needed?

7.3 We would be interested to learn whether it is generally accepted that reform is necessary and desirable in this area of the law. Are there any areas in which it might be considered preferable to do nothing?

(2) Tests of capacity

7.4 We welcome views upon whether there is scope for simplifying and rationalising the various legal tests of capacity in operation at present, and upon whether any individual test is felt to operate unsatisfactorily and be in need of review (paras. 2.15 - 2.31). Proposals for changes or alternative tests would be of particular interest, especially in the light of medical and psychological approaches to assessing capacity (paras. 2.36 - 2.42). Opinions are also sought upon whether the present approach of the law in defining capacity in cognitive terms is correct, and whether this "function" approach should be continued (paras. 2.43 - 2.45). Is it felt that further guidance is needed for professionals and carers upon the practical application of tests of capacity? If so, in what circumstances does this need most frequently arise and how might it best be supplied?

(3) Broad approach

7.5 We are particularly concerned to obtain guidance upon the best general approach to adopt. If it is felt that there are a number of urgent problems which could best be dealt with separately, this would seem to lead to a minimalist (para. 4.11) or an incremental approach (para. 4.12) to reform. On the other hand, it may be felt that a single, unified system is the best way forward (para. 4.13). We also welcome views upon the proper balance to be held between formality, in the sense of requiring the use of formal legal machinery, and informality (paras. 4.6, 4.7, 4.14 - 4.16), and whether there are any good reasons for retaining the present separation between matters relating to personal care and welfare and financial and property matters (para. 4.3).

(4) The underlying philosophy

7.6 Views are sought upon the principles and values upon which any reforms should be based (paras.4.17 - 4.24), and upon how conflicts of principle and interest may best be resolved (paras. 1.12 - 1.16, 4.25, 4.26).

(5) Advance directives

7.7 We would like to discover whether advance directives are in general seen as a useful and constructive development (paras. 6.2 - 6.4). We would be interested in hearing from those with experience of the use and operation of enduring powers of attorney (paras. 3.10 - 3.14, 6.15, 6.16), and to receive views upon whether the concept should be developed further in this country, and if so, in what ways (paras. 6.5 - 6.14). Ideas about how to reconcile the conflict between the need to provide a quick, inexpensive and accessible form of delegation and the need for effective supervision to prevent abuse would be of particular interest.

(6) Designated decision-making procedures

7.8 We welcome views upon whether statutory decision-making procedures without judicial review might be an acceptable and successful method to adopt in some areas. Is, for example, some statutory clarification of the principles in Re F. and the doctrine of necessity a realistic option to resolve problems relating to medical treatment? (paras. 2.18 - 2.24). We would be interested to receive ideas upon the best way of choosing alternative decision-makers, and whether it is feasible to devise some method of prescribing who they shall be (paras. 6.17 - 6.25). There are a number of existing models and proposals in this area, including the consent to treatment provisions

of the Mental Health Act 1983 (paras. 6.26, 6.27), and the proposals from MENCAP (paras. 6.28, 6.42), and the B.M.A. (para. 6.29). Comments upon the respective merits of these different models are invited.

(7) Reformed emergency procedures

7.9 It would be possible to deal with crisis intervention powers, providing protection against abuse or neglect, either as a discrete topic, or as part of a wider framework dealing with the affairs of mentally incapacitated people as a whole. We would be interested to hear whether one approach is considered to be preferable to the other and the reasons for this (paras.6.33 - 6.35). Views are also invited upon whether the present criminal offences relating to the sexual abuse of mentally incapacitated people are satisfactory (para. 2.27), if not, how the position might be improved and how, if at all, these might relate to new emergency procedures. The problem of maintaining the balance between protection from harm and abuse and respect for individual rights is particularly acute in this area, and we welcome ideas about how the correct balance might be struck and maintained.

(8) Reform existing procedures

7.10 This would basically involve overhauling and expanding the existing provisions for guardianship under the Mental Health Act 1983 (paras. 3.24 - 3.34), and the property management functions of the Court of Protection (paras. 3.6 - 3.9). We welcome comments upon how this could be done, and whether (perhaps in combination with other measures, such as advance directives and reformed emergency powers) this would prove a more or less practical starting point than the creation of a new statutory institution (paras. 6.36 - 6.40).

(9) Advocacy

7.11 The traditional view of substitute decision-making involves the assumption of authority by the guardian and sometimes by a court over a mentally incapacitated person. By contrast, advocacy sees this preoccupation with the authoritarian nature of decision-making as irrelevant and is concerned instead with the expression of the mentally incapacitated person's own point of view, facilitating the exercise of his rights and enforcing his entitlement to services (paras. 6.47 - 6.49). Views are sought upon whether these two approaches are mutually exclusive, or whether elements of each might be combined successfully.

(10) A new institution

7.12 We would be interested to learn how much support there is for a new institution, and to receive views upon the form this might take. Possibilities include some form of extended minority (paras. 6.30 - 6.31), the proposals of Scottish Action on Dementia (paras. 6.44, 6.45), and a new system of flexible guardianship along the lines adopted elsewhere (paras. 6.50 - 6.51).

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